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# **NURSING THE IMAGE**

**Popular fictions, recruitment and nursing identity 1950-1975**

**Thesis submitted for the Degree of Ph.D**

**by**

**JULIA HALLAM**

**Centre for the study of Women and Gender**

**University of Warwick**

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## **ABSTRACT**

This thesis examines popular images of nursing and nurses and their relation to issues of professional practice and personal identity in the changing health care climate of post-war Britain. The study explores issues of representation in British films, romantic novels and television programmes, as well as in the recruitment literature produced by the government and the profession. Case studies and autobiographical writings are used to situate these images in the context of personal nursing identities.

An analysis of the literature on images of nursing in Britain reveals a dependency on North American empirical research in spite of the very different institutional frameworks of both the media and the health care system in Britain. This thesis contributes a substantive empirical investigation of popular representations of nurses, nursing and nursing life in Britain focusing on popular fictional forms. The thesis argues distinctively that there is a strong correlation between these forms, images used to attract young women to the profession, professional nursing ideologies and models of nursing practice. An analytical focus on representations of class, gender and race reveals a white middle-class feminine ethos underpinning claims to professional autonomy and practice. This image is located as a source of internecine debates and struggles in nursing throughout the post war period.

Case studies and autobiographies personalise the political struggles outlined above, placing individual experiences of becoming a nurse in the context of training and working in a rapidly changing health care environment. A history of nursing focusing on the experience of skilled practitioners has yet to be written; this work is an initial contribution to that effort.

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## INTRODUCTION

### A general outline to the contents of the thesis

*‘Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid - in other words, every woman is a nurse’*

(Florence Nightingale quoted in Poovey 1989: 185)

Since Florence Nightingale’s day, nursing and female identity have been difficult to prise apart. Often identified as the founder of modern nursing, and the only woman ever to appear on a banknote in modern Britain, Nightingale’s image has entered the realms of popular mythology as one of a very few ‘good and great’ English women. Feminist historians have revealed however that Nightingale’s image was mobilised, even in her own time, to serve colonial and nationalistic aspirations. In her ambition to forge a profession for women and rally middle-class women to her cause, Nightingale mobilised images of the Victorian middle-class mother, the ‘angel in the house’ as nursing’s feminine ideal. But Nightingale also mobilised another, now more hidden discourse that has popularly survived in the figure of ‘the battleaxe’; this military image of authoritarian female power served an explicitly colonial aim of reforming and recreating the homes of the sick poor into a facsimile of the female, middle-class home. In her examination of Nightingale’s use of rhetoric, Mary Poovey argues that the Victorian ideal of submission and domesticity always contained an aggressive component. For Nightingale, the role of the nurse was not

only to care for the sick, but to become a public agent of moral reform, and through this agency, to ultimately undermine the power of medical men (Poovey 1989: 191-192).

Poovey's work lays the foundations for a study claiming that the stereotypes that inhabit popular modern conceptions of nursing identity - the ministering angel, doctor's handmaiden, the battleaxe and the sexy nurse - are the products of particular discursive configurations that both shape and reflect the practice of modern nursing in western culture. Whilst these images can be closely mapped against other prevailing images of women - as virgins, self sacrificing martyrs, whores, formidable old hags, and 'man's little helper' - the argument here is that nursing policy and practice adapts or resists these currents in particular ways at particular times. It is my contention that images of nurses have particular resonances at different times, and that these resonances are affected by a range of external socio-historical factors articulating with internal struggles and interests that give emphasis to one image rather than another at any one given time.

Femininity, claims Dorothy Smith, is a discourse (Smith 1988); women construct their femininities from a range of available texts choosing the kinds of femininity that seem most appropriate for their circumstantial modes of operation. Smith gives femininity a dynamic, contingent quality which I find in accord with my own experiences - as disco dancer, nurse, feminist, community artist and activist, and more latterly, academic - all of which have demanded a specific public presentation of the self. Smith's theory seems to suggest that there are no limitations on the

feminine identities individuals can select, but to bowdlerise a commonly cited expression from Marx, women often make these choices under conditions not of their own choosing. Within this context, nursing becomes one discourse of femininity amongst others, a potentially available choice for some (but not all) women. Representations of nursing in various forms - as stories, pictures, books, films and recruitment literature - are all part of a circulating discourse in which individual decisions about becoming a nurse can take place.

For those that have chosen to be nurses and survive the training, 'personal identity is inextricably bound up with identity as a nurse' claims Jillian MacGuire after an in-depth analysis of the literature on nursing recruitment and attrition (1969: 107). What MacGuire omits to point out, so much was it taken for granted at the time, is that it was *female* identity and nursing identity that were inextricably connected - and not just any female identity, but that of young, white, upwardly mobile working-class and middle-class females. For these groups of women, becoming a nurse meant an investment of time and energy in the training process on the basis that they would achieve social status and a career with good prospects; it also entailed an emotional investment in the ethical and moral framework of caring on which the training was based.

In recent years, feminists have been increasingly interested in the role played by popular texts in the formation of female identities. From an initial focus on content analysis, a range of analytical techniques have been developed that tend to emphasise either the formal structure of texts and their psychic and/or semiotic properties (as in

much recent feminist film theory) or their reading and interpretative aspects (such as methods of audience ethnography used in media studies). To date, these different approaches, emerging from separate schools of thought, have sometimes had an awkward correspondence. This is partly because the structures of academic disciplines and their institutional frameworks can be a barrier to the creation of fluid interdisciplinary and multi-disciplinary knowledges.

Historically however, nursing has been seen as both a science and an art (see for example, Pavey 1938). As a subject, 'nursing demands inter-disciplinary as well as multi-disciplinary approaches' (Briggs in Skevington, 1983, forward). This thesis aims to build bridges across the barriers of academic demarcation through a focus on the image of nursing across a range of what are usually constructed as discrete fields of enquiry. Using early feminist work on content analysis, later semiotic work on image construction and current work on reading and interpretation, the discursive patterns of nursing imagery are traced across popular, professional and personal discourses of nursing identity.

Most current analyses of the image of nursing are based on systematic empirical work by North American scholars who focus on content, on the roles performed by female nurses in popular fictional forms. This work has contributed a broad understanding to the way that female nurses are represented in popular culture - as ministering angels, doctor's handmaidens, battleaxes and sex objects - but it tends to be uncritically accepted in British nursing research in spite of the fact that the North American medical and media institutions operate very differently to their British

counterparts. To date, there has been no systematic empirically grounded examination of the image of nursing in Britain. This thesis begins to map that terrain.

Studying a popular image such as nursing demands an investigation beyond one textual form because popular images tend to reinforce each other across a range of textual practices. The forms selected for study here are films, career novels for girls, medical melodramas on television and doctor/nurse romances; women's magazines, a rich source of additional information have not been included because of constraints of time and resources on doctoral thesis writing. Rather than concentrating solely on fictional images of nursing in mass circulation, however, this study seeks to explore the relationship of popular stories and images to material often considered to be more factual in content. Recruitment images are an important source of information and inspiration for those considering nurse training. The recruitment literature examined here sought to influence the decisions of primarily young women at pivotal points of change in their lives. The relationship between professional 'factions' and popular fictions and the ideals of nursing that these images reinforce and/or contradict are revelatory not only of popular projections of nursing identity but also of the professional ideologies and attitudes that underlie them.

The thesis argues that the projection of nursing as a feminine ideal is constituent of as well as reflective of professional nursings' ideological and material practices. An analytical focus on issues of class, gender and race reveals a white middle-class feminine ethos underpinning claims to professional autonomy and practice. This



image plays a key role in shaping both professional and personal attitudes to nursing identity, and is located as a key source of the internecine debates and struggles which racked the profession throughout the years from 1950-1975. In depth interviews with a range of women who trained as nurses during this time illuminate personal experiences and attitudes towards nursing as a career, raising pertinent questions about the exclusion of particular groups from conventional accounts of nursing history.

In its totality, the thesis contributes to an understanding of the key role played by images in shaping both institutional and personal ideas and attitudes to nursing identity throughout the years from 1950-1975. It forms part of a larger feminist project concerned with mapping and analysing institutionalised discourses of femininity and their complex relationship to individual female identities.

My own decision to become a nurse depended to a considerable extent on local and familial interpretations of social and historical factors which formed part of the cultural milieu through which the possibility of nursing as a job for women was mediated. Examining these cultural configurations within fictional narratives and recruitment literature reveals how the role of the nurse in society is given public meaning and status at any given time, and why particular variations of nursing identity seem to predominate in certain periods. By defining the timescale of this study to the years in which I grew up and became a nurse, I have been able to explore and analyse the socio-cultural contexts of my own subject formation, thereby

making my personal biography both a methodological tool to structure the thesis, and at the same time placing personal experience in a public context.

The decision to approach the thesis in this manner reflects the way in which I remember specific moments of my own childhood and adolescence, and how these deeply ingrained experiences shaped my world view, my early choice of reading, and ultimately my decision to become a nurse. My childhood dilemma of ‘what to do when I grow up’ was clouded by a deep dread of war. Born at the tail end of the ‘baby boom’ generation in the early 1950s, I was a cold war child. During much of my childhood, cold war politics generated a fear of nuclear war that created a chronic anxiety state in those around me. I grew up in an emotional environment totally saturated with fear of war which I remember experiencing in three ways; indirectly through my mother’s stories of her war-time experiences, directly through family and group civil defence exercises in preparation for nuclear war, and morally through a religious insistence that another war would mean the end of the world. I was constantly asking myself, ‘what will I do if war breaks out?’ and giving the question two answers, both of which formed a locus of childhood imaginings and inflected my choice of entertainment. One solution was to run away, and Africa, where the women in the images I poured over looked majestic, brave and fearless was my first choice of somewhere to run to. (I now realise that this impression of fearlessness is conveyed because the women look directly out of the photographs at the reader, whereas western women in photos at this time tended to avert their gaze from the camera, dropping their lids and creating the impression of looking slightly to the reader’s left or right.) The other solution was to stay at home and be brave, which

meant becoming a nurse or joining the army - the two seemed to be much of a muchness at the time.

Feminist work on representation in recent years tends to have focused either on the psychoanalytic aspects of textual subject formation or the sociological aspects of social subject formation, with a difficult correspondence between them. Here, the approach to the image is distinctly genealogical, but rather than searching for roots or origins, the starting point is generational. Around the time that I was born, nursing was undergoing fundamental changes as a result of the re-organisation of the health services in Britain into a state run, nationalised system. Re-organisation increased the demand for general nurses working in hospitals, and led to new demarcations in nursing work. The play of mediations between the ideals, practices and institutional formations of professional nursing, dominant ideological notions of femininity and personal desires and aspirations shape nursing selves. These conceptual configurations take different forms at different times and in different places but are always, in the final instance, socially, institutionally and individually determined.

The interplay between these mediations is divided here into three conceptual categories of study: the popular imagination, which focuses on images of nursing in films, books and television dramas; the professional imagination, which traces ideals of professional identity as presented in recruitment literature; and the personal imagination which explores the aspirations and experiences of women who became nurses during this period. In order to facilitate a socio-cultural analysis that is

historically concise and to create a framework in which it is possible to analyse these categories and their interconnectedness, I have concentrated on particular 'moments' when there seems to have been a groundswell of dense public activity featuring nursing and nurses across various texts in a range of media forms. Three such 'moments' can be identified: one in the late 1940s and early 'fifties, one from the late 1950s to the early 'sixties and one from the late 1960s to the mid 'seventies.

Organising an analysis in blocks of chronological moments in this way has the problem of re-enforcing the notion that periods of time are discrete entities, each with their own particular characteristics, rather than on-going continuums of dialectical negotiations with peaks and troughs of activity. Nonetheless, an analysis based on particular moments is a useful one for a materialist feminist cultural analysis since it can serve to point out some of the complexities of the relationship between cultural producers, their re-presentations of images, and the audiences/readers who consume cultural products. In semiotic terms, this is an attempt to read texts and images synchronically, and then place that reading in a broader diachronic framework. This method enables some conclusions to be drawn about changing meanings in the 'discourses of femininity', the texts around which different women construct their individual female identities.

### **Thesis organisation and structure.**

The thesis is structured in four chapters, starting with a literature review of nurses' writing on the nursing image, and progressing to popular images in films, books and on television; these are then compared with recruitment images in nursing literature,

and used to analyse personal accounts of nursing training and professional assimilation. The final chapter pulls together some of the principle ideas in the thesis through an outline of the research process. Each chapter is sub-divided into an introductory section with a note on its methods and methodology, and is then organised around the identified historical moments when there were groundswells of activity in nursing imagery. These changes are related to the challenge to nursing's white female middle-class identity created by different groups in nursing and professional responses to issues of class, gender and race foregrounded by the groups.

The literature review revealed, somewhat surprisingly, that in spite of a growing awareness amongst nurses in the 1980s of the importance of a positive public image of nursing, there has been little recent commentary on how media images and public perception relate to professional identity and personal morale. When the image of nursing in Britain is discussed, it tends towards a 'positive image' approach supported with empirical work culled from the United States. This is problematic for several reasons. First of all, calling for a positive image of the profession assumes that there is a general consensus (professionally) about what constitutes such an image. Secondly, a positive image in professional nursing's terms may constitute a less than positive image amongst those who use nursing services or who view themselves as potential users - two influential interest groups within the general public. Thirdly, apart from the obvious differences in nursing culture between Britain and North America based on their separate institutional and economic frameworks, there are also major differences in their media cultures for similar reasons. Any attempt at cross comparability presents problems other than at a broadly structural, non-specific level

of analysis.

The second part of Chapter 1 contains an analysis of images of nurses circulating in Britain throughout the period based on systematic empirical investigation in archives, book stores and libraries with popularity as an important selective criteria. The fictions span a wide field, encompassing feature films, television productions, and popular romantic fiction. Although the relationship between women and the nursing profession is discursively predicated on the relationship between middle-class white femininity and differences of class, gender and race, these differences tend to be buried in most of the popular fictional narratives between 1950 and 1975. They can however be found as 'traces', often in the form of cameos or subsidiary characteristics that work to support professional ideals and values. The stories of nurses I am going to discuss all feature white middle-class heroines, re-presented in fairly specific narrative patterns according to their generic form. In popular romance literature for example, the medical romance has become a category of its own, sitting alongside historical romances as a specific genre that readers can easily recognise. This fictional form, where achieving the desired male object motivates the narrative action and its resolution, does not have a direct counterpart on the big screen. Although nurse characters in movies often do have romances with medical men, (eg **The Feminine Touch**, GB 1956) films have tended, more than any other medium, to portray nurses either as self-sacrificing heroines who give their lives to serve the sick, (**The Lady with the Lamp**, GB 1951) or as malevolent castrators who use their position of power to subjugate those in their care (**Woman of Straw** GB 1964). On television, the nurse usually appears in medical melodramas, where she is amongst

a range of characters who re-present modern hospital life and work (**Emergency Ward 10**, GB 1957-67). In these dramas, nurses are often subsidiary characters to the medical staff who are the focus of the action, but occasionally medical soaps and dramas have concentrated on nurses and nursing as the central focus of narrative action (**Angels** GB 1975-78, 79-84). My account pays particular attention to the latter.

In Chapter 2 of the thesis, these images are compared with images sanctioned by the nursing profession to represent its ideals and values, those used on recruitment brochures and leaflets. As well as tracing how public meanings of nursing circulate, I want to explore what I have termed 'the professional imagination', nursing's idealised view of itself. What kind of textual strategies were used to 'advertise' nursing to its prospective trainees, and how did these strategies relate to the fictional modes used in popular novels, films and television programmes? As well as identifying recruitment strategies, Chapter 2 examines the discourses of professional nursing in the post war era, using the recruitment images to argue that nursing's professional institutions continued to reinforce white middle-class ideals of professionalism. Lying at the core of nursing's problem of how to present a coherent image of modern nursing identity were two factions with different ideologies of nursing practice: the problem solving professional specialists and experts, and the task centred practical managers and administrators. In these two groups, it is possible to see the evolution of Nightingale's discursive binary oppositions between the domestic ideal and the military model into two distinct and oppositional branches of hospital nursing practice.

In the third chapter of the thesis I map personal narratives of becoming and being a nurse, including both autobiographical accounts and case studies, against the broader socio-historical contexts of popular nursing stereotypes and the more narrow, constrained context of professional discourses on staff recruitment. The decision to interview women who became nurses about their memories of early images of nursing initially stemmed from a basic dissatisfaction with forms of analysis that claim only a textually determined subjectivity for their readers. In the final section of this chapter, interviewees' self-concepts of the 'proper nurse' are used to explore Jillian McGuire's claim that the personal identities of women who become nurses are irrevocably altered by training and experience.

The final chapter of the thesis, the research imagination, pulls together the methodological threads that run throughout the thesis. Autobiography and case studies are used as a means to locate this work and its field of interest in a specific period of women's history, the time in which 'second wave' feminism began to question the power of texts and images by pointing out the gendered bias of their authority. It is during this period, in early 1970s Britain, when a new wave of feminist ideas began to circulate outside of academic institutions, that many women began to question why our opinions did not matter and why we always seemed to end up doing the dirty work no matter how hard we strived to do something else. Some academic feminists are busy constructing a history of second wave feminism as a history of women writers who have written 'seminal' works of feminist knowledge and attained positions of (relative) cultural power within academic institutions. Like most movements for change however, the women's movement could not have



happened if women had not moved themselves, in vast numbers and in a myriad of different ways. Nursing and nurses, for all the apparent institutional intransigence displayed by the profession, was and is a part of this movement for change in women's lives. It is to these women that this thesis is dedicated.

## **CHAPTER 1**

### **The Public Imagination: A general introduction**

During the first twenty five years covered by this study, public perceptions of nurses changed markedly, a process mediated by a number of factors. Of particular concern here are the roles played by mass media forms, in particular the increasing presence on television of dramas and documentaries about medicine and hospital life, and the growth of a mass market for doctor nurse romance fiction. In this first chapter, I want to look at popular representations of nurses primarily in the period from 1950-75, examining images created in popular novels and career books for girls, films, TV drama series and documentaries.

The chapter is organised in five parts, starting with a review of the literature that nurses have written on images of nursing. The four succeeding sections focus on specific periods when clusters of production activity reflect changing public interests in images of nursing and medicine. The images selected for analysis are those that predominately deal with experiences of nursing training and through that experience, introduce the reader to stories of modern hospital life. Many of the stories feed an appetite for tales of female heroism, romance and mystery played out through life and death dramas against a backdrop of contemporary medical facts and information.

But it was not only romantic images of handsome young doctors and pretty, feminine

nurses that fuelled the growing interest in stories about nursing and medicine. These texts also fed a desire for knowledge. They offer maps of possibilities - the possibility of a certain kind of femininity, the possibility of a particular way of life, the possibility of professionalising (and earning money from) the 'womanly' skills associated with caring for people. They also hint at other possibilities - of gaining knowledge about the body and its functions, of healing, of life and death itself. In many of the narratives selected for study here the stories map a journey from innocence to experience, the transition from girlhood to womanhood, through the process of nurse training. All the texts tend to have a nurse figure or figures as major characters in their narratives. She is often the person through whom the story is told, the central character of narrative agency, who both initiates action and around whom the action happens. Central characters in fictional narratives are the characters readers are most likely to identify with, and therefore it is likely that when the central character is a nurse, female readers can take the opportunity to identify themselves with that character. The concept of identification has been particularly foregrounded in literary and film theory in recent years. This study argues that these theories need to be grounded in a historical materialist perspective that situates identification within specific socio-historical contexts at particular points in time.

For analytical purposes, the chapter is divided into three specific periods when the image of nursing had quite different public personas. The first period, in section two of the chapter, looks at the immediate aftermath of the second world war and the formation of the national health service, starting with two films that present nurse training in fictional form on the big screen - what we might term now 'drama

documentaries' of becoming a nurse. The emphasis in this section is on post-war attitudes towards nursing as a career for women in fictional 'recruitment' films and career novels for girls. At the beginning of the 'fifties, a strong service ethos pervaded notions of professional nursing identity. Nursing was generally regarded as hard and dirty work, it was poorly paid, and a sense of vocation was considered essential in order to be able to do it. Whilst the films of the time tended to emphasise the vocational aspect of nursing work, career novels for girls painted a somewhat different picture, presenting nursing as an extension of white middle-class feminine values exemplified in the descriptions of clothes, dress codes and fashion that pepper their pages.

Changes in the image of nursing on the big screen, the arrival of small screen medical melodramas and the growth in popularity of medical romance novels are analysed in relation to the changing context of medical care in part three. Between the late 1950s and the early 'sixties, medicine developed an increasingly technological base which changed the image of nursing. No longer is nursing presented as serving 'the community', with an underlying implication that to serve the sick is to serve the nation. In the post-war society new ideas of service begin to prevail which show nurses ministering to the needs of the new scientific technologies of cure rather than traditional nursing ideologies of care.

Nowhere is this more apparent than in the proliferation of images of nurses silently caring for mythical, god-like medical men. The newly developing international image markets in television programmes made the North American spectacle of the heroic

white doctor increasingly available to British audiences. Nurses became background presences in small screen melodramas, whilst on the big screen they were satirised as petty authoritarians and sexually frustrated spinsters, or depicted as creatures of sex. Part four points out that only in the critically despised 'women's genre' of romantic fiction could an image of nursing be found that gave nurses minds, bodies and voices of their own. Written by women for female readers, these stories told not only of passionate love between nurses and doctors, but negotiated a range of personal and moral issues around the meaning of nursing that only later appeared in televisual form. In these books, a fascination with medical men is part of a fascination with medical knowledge; to learn about one is to get to know the other, to see behind the mask of curative medicine to the driving (male) force behind it. The journey from innocence to experience that so many of these books portray is one that maps out the possibility of combining a career and marriage through partnership with a medical man. Caring is restored on an equal footing with curing because the man is dependent on the woman's capacity to provide it, and it is his acknowledgement of his need for her caring capacities that ultimately makes the nurse powerful.

In part five of the chapter, the increasingly sexualised image of the nurse in the cinema is traced in relation to the expanding market for doctor/nurse romances and the large scale consumption of medical soaps on television. The public perception of nursing again underwent a sea change, but this time nurses themselves were actively altering the public understanding of their role through widespread campaigns for improved pay and better working conditions. The success of these claims raised

their public profile, and sparked a new interest in the fictional representation of nursing, at least on television. The popular television series **Angels** (BBC 1975-82), the first television drama to feature nurses as central characters, grows out of this new level of public interest.

Submerged since the early 1950s into fantasies of male medical power and female subordination, the eruption of the nurse into speech and visibility coincided with the beginnings of what is now regarded as second wave feminism. Generally excluded from feminist accounts of the period because of its symbiotic relationship with femininity and the female caring role, nursing's stand against the state can nonetheless be seen as part of the general discontent with women's position in society that swept through Britain during the late 1960s and early 'seventies. The effects on the image of nursing can in retrospect be seen as significant; although **Angels** now looks dated because of its slow narrative pace and pedestrian visual style, for the first time a serious drama series was commissioned by the BBC which totally centred on nurses. This was no small achievement for a female profession which throughout the post-war period had either been lampooned and satirised, or more often completely ignored.

First of all, then, I want to reflect and comment upon what nurses have said about their public image. What immediately follows is a literature review of work undertaken by nurses themselves to examine the image of nursing in the media. Some of the American work which refers to specific media in considerable detail is not included at this stage, but will be discussed in more depth in the relevant sections of the chapter.

## **Part 1**

### **Nurses reading images of nurses.**

Media stereotypes of nurses have increasingly been questioned and challenged by nurses themselves in the past twenty years. In a recent article reviewing the literature on images of the nurse and nursing in the media, Jacqueline Bridges, a staff nurse at Manchester Royal Infirmary, asks 'What are the actual effects of these media stereotypes?'. Bridges identifies four areas of concern, based on the work of Kalisch and Kalisch 1982a and 1982b, Hughes 1980 and Roper 1976. First of all, she voices a concern identified by Kalisch and Kalisch - that 'these portrayals affect nurses' self-images and undermine nurses' self-confidence, beliefs and values.' Secondly, using Hughes, she points out that public opinion is inevitably shaped and informed by the mass media and that 'public opinion of the nurse has had and will continue to have an effect on the ability of the nursing profession to provide a unique and beneficial service to the public.' Thirdly, she is concerned about how these images affect the decisions of politicians and policy makers when allocating health care resources, and last but not least she points out that 'the public image of nurses will affect recruitment into the profession' (Bridges 1990: 850-854).

So what are the media stereotypes that have aroused the concern of Bridges and other nurses? And to what extent are the four areas of concern identified by Bridges the result of a public imagination that is seen by these nurses as dominated by

stereotypical images circulated through the mass media forms of book, magazine and newspaper publishing, cinema and television?

Nursing's relationship to femininity is a recurring theme in much of the literature on images of nursing that has emanated from the profession in recent years. What most of this literature has in common is a concern with the content of popular fictional forms, and how nurses are represented in them. In nursing terms, the binary stereotypes of femininity, the virgin and the whore, take on a set of particular characteristics that clearly have their origins in early Victorian ideals about the 'essential' nature of the feminine. The 'good' nurse has invariably been seen as some form of self-sacrificing angel who gives up everything to dedicate her life to caring for the sick. The 'bad' nurse is her exact opposite, misusing her position of power and authority over the sick individual to satisfy her own needs and desires, whether these are material, sexual or simply sadistic.

Until relatively recently, nurses paid little attention to their re-presentations in popular fictions, although they did devote considerable energy to securing a feminine ideal of vocational asexuality in the early days of establishing nursing as a respectable profession for upper and middle-class women (Garmarnikow 1978, Simnett 1986). It was only after the nationalisation of the hospitals and health services in Britain that an increased awareness of the public's image of nursing grew within the profession in response to a massive shortage of nursing labour. Severe problems of recruitment and attrition led to a series of studies and reports which finally culminated in a government enquiry into the image of nursing, known as the Briggs report. These



issues are discussed in considerable depth in Chapter 2, but at this point it is important to note that nurses generated little by way of commentary or analysis on their public image until after the publication of this report in 1972.

Because of the acute problems of recruiting women into nursing in the newly formed NHS, much of the writing on the image of nursing during the late 1940s, 'fifties and 'sixties tends to focus on the attitudes of young women towards nursing as a career. This work was reviewed and summarised by Jillian MacGuire in 1969 under a series of subheadings which included recruitment and selection, training and withdrawal, sickness absence, the qualified nurse and the hospital environment. MacGuire's summary of findings in these research abstracts that pertain to 'the general public' and its knowledge of and attitude to nursing is worth quoting at some length, since it is a summary of all the empirically researched sources of information available at that time:

1. Out of teaching, secretarial work, nursing and bank clerking, secretarial work and teaching are seen as a more suitable 'first choice' career for girls leaving school than nursing.
2. Nursing is seen as involving harder work than any of the other three.
3. Nursing is seen as the most worthwhile job.
4. Adults in general have a more favourable view of nursing than girls in the main recruitment age of 16-24.
5. Three out of five adults know what SRN stands for, two in five know what SEN stands for.
6. Adults think that nurses work harder than other people.

7. Two in three adults think that nurses are underpaid.
8. Two out of three in the general population would encourage a daughter to take up nursing.
9. Mothers and housewives are no more critical of nursing than are working women in general.

Interestingly, MacGuire points out that in the National Opinion Poll study **Attitudes to Nurses** (an unpublished report for the Department of Health, 1966), nursing was rated higher by women, older people, those in the lower social classes, those who had left school early and those in the Midland and West regions. It was generally viewed as not requiring as much intelligence as teaching, and most agreed that to be a nurse you had to have a vocation. A large percentage thought nurses spent a lot of time doing chores, that nurses were subjected to more discipline than was necessary and worked longer hours than most people (MacGuire 1969: 150).

Several points can be drawn out from the above that have relevance for the study of popular fictional images of the period. First of all, career choices for women, even by the late 'sixties, seem to still be extremely limited. Perhaps this is one of the reasons why respondents in the AB group categories were more likely to encourage their daughters to nurse than respondents in the DE group, especially since more than 80% of the substantial sample thought it was difficult to become a nurse. Nonetheless, given the views about the lower intelligence of nurses, doing chores, the discipline, and low pay, this seems to point to a middle-class belief about the suitability of particular forms of work for women. This will be discussed in more detail in the next section of the chapter, particularly in relation to nursing career

books for girls. Secondly, male respondents in general rated nursing less highly than women although throughout this period they would have been considering nursing as a career choice only for their daughters, not for their sons. This low rating by men, given the limited range of career options for their daughters, must mean that they preferred them to embark on careers as secretaries or teachers, the higher rated options. The male relationship to images of nursing will be the focus of debates in the second section of this chapter, for it is in the late 1950s that images of nurses become 'irreverent', particularly in the films of the period - a trend that continues into the 'seventies. Thirdly, women of all social classes generally rated nursing higher than men, perhaps in part as a result of the limited horizons available to them, but also, I will argue, because of two particular fascinations which seem to have pervaded women's fantasies in the post-war world. One of these was a fascination with the promise of 'miracle cures' promoted by the medical establishment, and the other a fascination with middle-class aspirations and ideals. These fascinations with medicine and middle-classness and their fictional embodiment in medical men form the basis of the discussion on medical romances and soap opera in the final two sections of the chapter.

MacGuire's review stands as an interesting benchmark between the functionalist, empirical work on public attitudes that depends on quantitative analysis as a methodological tool, and a trend towards content analysis and issues of representation that follows in the nursing literature of the 'seventies and 'eighties. Whereas in the earlier period, professional and governmental concerns with the public image of nursing were motivated by the need to find ways of reaching and attracting candidates

motivated by the need to find ways of reaching and attracting candidates who could be identified in some way as 'suitable for nursing', in the post Briggs era the focus shifts to an awareness of how public images misrepresent nurses and the nursing profession. This is now the dominant school of thought within the profession, as reflected in Bridges' (1990) analysis. Women working as nurses began to actively contest media representations of their role and their work, adopting an approach which tends to 'blame' the mass media for promoting false myths and fantasies. They began to challenge media stereotypes, claiming that mis-representation was leading to a poorly understood perception of their role by the general public. In 'Will the "real" nurse please stand up: the stereotype versus reality', American nurses Elms and Moorehead try to present an alternative picture to dominant fictional representations, claiming that the explaining, analysing and blaming of why the image is what it is by sociologists, psychologists and feminists respectively is doing little to alter the status quo. Instead they offer 'profiles, descriptions and clarifications to expose and dispel the stereotypes' (Elms and Moorehead 1977: 127).

A similar concern with mis-representation was also beginning to be voiced in British nursing circles. In an address to the International Council of Nursing's 16th Quadrennial Congress in Tokyo, 1977, Christine Chapman, Director of Advanced Nursing Studies at the Welsh National School of Medicine, University of Cardiff, presented a paper on the image of the nurse for a special interest session called 'How do we see ourselves and how do others see us?' (Chapman 1977). Chapman claims that in the western world, the mass media give clues to the images a group of workers may present. Whilst she appreciates the media's need to use stereotypes, she

questions the fact that on television nurses are portrayed as female, white, single and dedicated - as 'angels of mercy'. Tracing the history of the nursing image through Dickens' caricature of the pre-Nightingale nurse Sarey Gamp and the Nightingale reforms, Chapman claims that a positive image of the nurse still exists in the West. She uses recent research conducted by the RCN to prove her point, where it was found that 76% of patients had a positive image and high expectation of nurses, anticipating technical competence accompanied by gentleness, kindness, patience and sympathy (Anderson 1973). She then goes on to discuss the different expectations of patients, doctors, neophytes, and the profession wanting autonomy and recognition. Chapman asks, 'Can the nurse be all things to all men? Are these images and expectations mutually exclusive?' As a positive step to resolving some of these difficulties, Chapman ends by discussing the ways in which the profession can construct a more realistic image of nursing by seeking nurse advisors on TV programmes, correcting statements in the press and learned journals and making recruitment literature more realistic.

In Britain in the late 1970s, many of the debates about the representation of nursing tended to be carried out within non-nursing academic departments focusing on a re-writing of nursing history (see, for example, work by Dingwall 1978 and 1988, Davies 1980, Maggs 1983 and 1984). In North America, perhaps because of the greater emphasis on degree level education for nurses, nurses themselves were producing some interesting cultural work that foregrounded the question of public opinion through a historical study of popular magazines, novels and newspapers. Content analysis was used to formulate generalisations about public opinion and

identify themes that emerged during the period 1896-1976. Hughes' (1980) justification for her approach in her study 'The Public Image of the Nurse' has particular relevance for this chapter and is worth quoting more fully:

'The mass media have not only reflected but have also directed public opinion about the nurse and the nursing profession. From a historical perspective the image of the nurse that has been projected through the mass media has been a distortion of reality, grounded in mythical beliefs and traditional ideas that for too long have gone unchallenged and unquestioned by the general public and many nurses. The public image of the nurse may account, at least partially, for the failure of the public to fully utilise the services of the nurse in health care delivery' (Hughes 1980: 55).

Hughes' concern with public perception is motivated by a professional economic concern in the systems of payment that nurses are subjected to in the USA health care system. Without going into the details of that system here, her argument is that nurses will only become established as independent practitioners in their own right once they are paid directly for their services, rather than employed by others to perform those services on their behalf. As the consumers of health care services provided by nurses, only the public can create the demand for those services which will ensure that nurses function in non-traditional roles in the future. For Hughes then, the concern with the public image of the nurse has particular political implications which do not appear in British accounts, no doubt in part because of the different institutional organisation of the health care system here. This difference has to be taken into consideration when comparing accounts of the American image of nursing with the British context.

According to Hughes, the mass media have created a mythological image of the ideal nurse, and the public expect all practising nurses to adhere to that image. The personality of the nurse is emphasised and her appearance, negating the intellectual and educational requirements of nursing practice. Physical fitness is given precedence over intelligence in recruitment drives as late as 1943, and the timbre of the voice was seen as important attribute. A 1955 edition of **Look** defined the function of the nurse as 'giving injections, back rubs and bed baths (and) making a neat hospital bed'. A 1956 article in **The Reader's Digest** which claimed that, 'the responsiveness of a nurse comes more from her personality than from her formal education', even though the nurse is required to 'perform delicate tasks and exercise the kind of judgement that until recent years were the exclusive prerogatives of doctors'. As recently as 1971, **Life** reported that as a student nurse, one 'learns the right way to take a blood pressure, read a thermometer - and even empty a bedpan' (Hughes 1980: 63).

In addition to these physical typologies and personality traits, Hughes identifies persistent themes running through North American popular literature which are also prevalent in popular literature in Britain. These can be summarised as nursing as women's work, as virtue personified, as 'unwholesome', as a vocation. Mythical themes associated with the profession are those of 'the born nurse', 'the new road to matrimony' and 'physician's helpmate'. Interestingly, Hughes does not comment on (and perhaps therefore has found no trace of) myths about nurse's sexuality and their sexual availability, an image that pervades American medical melodramas from the late 1950s on.

Within the British context, Jane Salvage was also concerned about the myths of nursing perpetuated by mass media stereotypes. In 'Angles, not Angels', Salvage compares the assertive militancy of nurses during a recent NHS dispute with the mass produced fantasies of Mills and Boon doctor/nurse romances, claiming that these are only the most conspicuous of the media that 'present nurses as doctor's doting handmaidens, an image that pervades even NHS recruitment literature' (Salvage 1982: 12-13). Salvage is the first nurse to write in depth about the range of images in popular circulation in Britain, and how they affect the expectations of those entering the profession, as well as the general public:

'As the millions spent on advertising would seem to prove, constant bombardment with a particular message or symbol does have an effect. From the days when we little girls played nurses and you little boys played doctors, those stereotype figures have existed within us, fleshed out and naturalised by regular reinforcement from a variety of sources' (182: 13).

Salvage sees the media as constructing people's perceptions of nursing, concluding that, 'it is easy to find examples of how it is absorbed and reproduced by the very people it travesties' (1982: 13). To support this statement, she cites a recent uniform competition in the **Nursing Times** where the winner had designed an ultra feminine uniform that incorporated many of the traditional features. Salvage points to the connection between nursing, women's work and femininity encapsulated in the traditional uniform, and how it uses the black stockings of eroticism, the frigidity of the nun's cap and the chambermaid's apron of service,

'to bedeck the supposedly maternal image of a 'caring' job - images made by men in which many women have come to believe... male-defined images of



female sexuality are at the heart of all mythical nurse figures, most obviously in the 'naughty nurse' imagery in Soho films' (1982: 12).

Salvage claims that these images reinforce outdated ideas of medical domination, outdated working relationships, and fail to point out the skills and difficulties of the work. She thinks that the best way to defuse the myths is by adopting a plurality of images, since any single image is bound to be a crude reduction. 'Nurses must resist clichés, contest the traditional myths and make the fight against sexism a central activity in nursing politics' (Salvage 1982: 13). Salvage has been the foremost propounder of this view on the British nursing scene and has written at length about the relationship between nursing, gender and sexuality (Salvage 1985, 1987a, 1987b).

In the USA at this time, Janet Muff was writing in a similar vein. Her edited collection **Socialisation, Sexism and Stereotyping in Nursing** (1982) traces the relationship between nursing, gender and femininity from early infancy, through career choice and into professional nursing, where a significant collection of essays discuss strategies for change through political action. For both of these writers, empowering nursing professionally involves situating the self outside the discourses of femininity that currently pervade professional nursing practice and disempower the female attendant on the sick.

What more then, is there to be said? How will my work contribute to the debates in this field? I want to propose that it will contribute in two major ways. First of all, a cultural studies approach that examines the textual production of images in a

specific historical context can map change. In North America, for example, nursing scholars Kalisch and Kalisch have studied the representational content of images of nurses in film and television texts in considerable depth, but because these representations are abstracted from their contexts as the products of the mass media industries, the broader picture of the relationship between representations of nurses and representations of women more generally is lost. It was not, for example, only nurses who were subjected to increasingly misogynistic treatment in the movies of the 1960s and 1970s, but women in general (see, for example, Haskell 1974). The question to ask here, it seems to me, is not ‘why did this happen to representations of nursing?’, although that is an important question, but why, within the context of British film production, there was a changing emphasis from films that featured nurses as major characters such as Ealing’s **The Feminine Touch** (1956) to films that featured doctors as major characters, such as the popular ‘doctor’ series of the mid 1950s and early 60s. In British films, nurses disappear as characters of any major significance altogether; it is only with the beginnings of medical drama on television that nurses again resume any visibility or importance in narrative terms. Rather than searching for an ideal image in the media, the big question seems to be why particular representations of nursing become prevalent in different media at particular times.

Secondly, following Dorothy Smith’s methodology which is outlined in the next section of this chapter, the role of nurses themselves in constructing images of nurses is examined. As Salvage (1983a) perceptively notes, nurses do ‘collude’ with the mass media in creating a particular hegemonic image of nursing. On the flyleaf of many doctor/nurse romances for example, one can often find a detailed statement of

the author's nursing credentials including details of her training and work experience. The question in my mind is what do women find pleasurable in the telling of these stories, and what do women find enjoyable about reading them?

In this chapter, the focus on fictional images follows my own growth pattern of the consumption of these images with one exception, that of film. The cinematic image of nursing was already in decline by the time I was old enough to go to the pictures, and I have few memories of nurses on the big screen. Sister tutors in charge of recruitment during the late 1940s and 'fifties claim however that the cinema was a major influence on the nurses they admitted to training. Since it was this generation of nurses that by the 1970s was training me, I wanted to trace the images and ideologies of nursing circulating in their formative training period. Until the end of the 'forties, women formed the majority of cinema's audience. Nursing and hospital films of this period are therefore crucial to an understanding not only of the relationship between the cinematic image and the public perception of the nursing role, but the nursing profession's idealised view of itself.

## Part 2

### Reification and Recruitment

#### **Images in post-war Britain.**

The films and books under consideration in this section have a pre-occupation with 'instruction' or 'education and information' that is missing from many of the nursing fictions produced in later periods. Several reasons are proposed here for this emphasis, some of which are dealt with in relation to the films, the others in relation to career novels for girls. Only British films are considered in depth in this section, although it is likely that cinema goers at the time would have been as familiar with Hollywood images of nurses and nursing as they were with the British product. Films like **The Citadel** (GB 1938) - made by MGM's British studio - and **Vigil in the Night** (US 1940) were written by the British writer A.J Cronin but produced and distributed by American film companies. The movement of creative talent and personnel between the British film industry and Hollywood was common practice in the film industry at the time. Much has been written about the domination of British film distribution by American companies and the attempts by British companies, particularly J.Arthur Rank, to break into the American market (see, for instance, Murphy 1982 and 1989; NacNab 1993). The history of the British film industry throughout this period is not the particular concern of this thesis, but it is important to note that my division into British and American films is in some ways an arbitrary one from an audience point of view. American films were the most popular films at the box office throughout the period of this study, as Thumin (1992) has shown.

American films about nursing are therefore part of the cinematic context within which British films about nursing were circulating. Some details are given on the Hollywood image of nursing as a contextual background to the overall trajectory of representation, not only because the audience would have seen and enjoyed these films but because of the British film industry's concern with making products that would appeal to the American audience. By the late 1940s, there was considerable American investment in film production in Britain; the British film industry, as well as the British cinema audience, was heavily influenced by and familiar with the American product.

In a similar way, it is difficult to draw clear lines of national specificity around the two most popular series of nursing career novels for girls, the **Sue Barton** and **Cherry Ames** books. Both were written by American writers but became widely available in Britain shortly after publication. Within a short space of time, they were available for loan on the shelves of local public libraries, and are still available today although now out of print. Many women I have spoken to recall reading these novels in their youth; this seems to apply to women from a wide variety of backgrounds and of different ages.

Throughout the post war period, the popular image of nursing in Britain is heavily mediated by American fictional texts, both on the big screen and in books, but the lack of contextualising information in these texts creates an image of nursing that seems able to transcend barriers of national identity and other differences into an all-embracing professional ideal of white, middle-class femininity.

## **The films.**

Some of the most thorough work on images of nurses in the movies has been undertaken by the American nursing scholars Kalisch and Kalisch (1982b), who base their conclusions on content analysis of the nurse's role and function in over two hundred motion pictures produced between 1930 and 1979. Kalisch and Kalisch see the period between 1930 and 1945 as the heyday of positive images of nursing and nurses on the big screen. The only American feature length films that focused entirely on nursing were released during this time: **Night Nurse** (1931), **Once to Every Woman** (1934), **The White Parade** (1934), **Registered Nurse** (1934), **Wife, Doctor and Nurse** (1937), **Four Girls in White** (1939), and **Vigil in the Night** (1940). Throughout this period, nursing is portrayed as a worthy and important profession that enabled women to earn a living without compromising ideal feminine values. They see this portrayal developing in relation to other new models for working women which were emerging in the depression years of 1930s America, a period of economic collapse and retrenchment. **The White Parade** (1934) is described as a 'realistic and sympathetic portrayal of the difficulties of becoming a nurse' in a large hospital school (1982b: 607). The story emphasises that not every woman is cut out to be a nurse, that nursing entails a life of hard work and little monetary reward but that it affords enormous personal satisfaction. At the end of the film, the heroine (sic) turns down marriage to a millionaire in order to continue working as a nurse. 'Marriage' to nursing is portrayed as equivalent to that of religious vocationalism, a higher calling demanding both idealism and self-sacrifice. During the depression era the prevailing image of nursing on the screen changed from the self-seeking and

consumerist values that had dominated the latter half of the 1920s, substituting ideas of self-sacrifice and virtue. Although all kinds of heroines were nurses, not one of them was a career nurse since careers were out of keeping with woman's legitimate destiny, marriage. By the mid 1930s, this view at least had undergone considerable transformation, with many of the later heroines determined to complete their nursing training (Kalisch and Kalisch 1982b: 607).

This analysis tells us very little about the relationship of American nurses and their professional institutions to the screen image of nursing, or why the sexualised image of some of the 1920s nurses becomes 'redeemed' during the depression. Kalisch and Kalisch's preference for the later films seems to be based on what they perceive as the 'realisticness' of the image and ignores the changing conventions of Hollywood cinematic practice, itself subject to rapid change which included both technological upheaval and pressure to censor much of its output. What Kalisch and Kalisch mean then when they point out the 'realism' of **The White Parade** is that this film upholds a particular set of meanings around the sign 'nurse' that are cognisant with their own nursing ideals. There is no ideological conflict between the filmmakers (in the broadest sense of the word) and the Kalischs' reading, no gaps in shared understanding or knowledge.

Richard Maltby has convincingly argued however that the Hollywood Production Code was instituted in 1934 to protect dominant ideologies at a time when economic recession was placing these ideologies under severe strain. His research has shown that the Production Code Administration regarded narrative structure as a strategy for

controlling meaning, and therefore particular narrative structures were used in the hope of reducing the possibility that contemporary audiences would develop oppositional identifications and ideas (Maltby 1990). One of the oppositional ideas that needed containing, according to Maltby, was the blatant display of consumerism through woman-centred spectacle as this was incompatible with the crisis of capital during the depression. Instead, there is a turn towards sacrifice films, where women give up material wealth to be broke but happy. The movement traced by the Kalischs between the 'twenties, when nurses gave up their charitable work to marry wealthy spouses, and the mid to late 'thirties when nurses sacrifice their matrimonial chances in order to work, seems to fit neatly with Maltby's argument. Kalisch and Kalisch do not comment on whether American nursing institutions capitalised on these images to bolster their recruitment during the depression years, leaving the relationship between cinematic images and professional nursing's relationship to them open to speculation and further research.

Somewhat surprisingly, the largest group of films to feature nurses were detective and crime stories. The Mary Roberts Rinehart character Miss Pinkerton and Mignon Eberhart's Sarah Keate became popular screen nurse sleuths, working as private duty nurses for wealthy patients and becoming embroiled in the mysterious goings-on of the mansions' other occupants. These films usually ended with the nurse in the arms of a police detective boyfriend, but they were not primarily romantic stories and did not end in marriage, or for that matter with their leading characters going mad or dying as was the fate of so many screen heroines. Kalisch and Kalisch like these films because the nurses display wit, mental acuity and courage; they are wordly



wise, not easily taken in by outward appearances, and yet are portrayed as sympathetic and kindly women. There is little attention paid to actual nursing care in these stories - nurses 'at most administered medications, took temperatures and delivered meals' (1982b: 608). By focusing on nurses as sleuths, a tactic that is used in the **Cherry Ames** books, nurses are portrayed as intelligent, rational women with logical powers of deduction who are capable of bravery, determination and forbearance. These films were very popular in the United States and were produced at the rate of one or two a year during the 1930s, but there is no researched evidence of their consumption and popularity in Britain.

With the entry of America into the second world war, nurses on the screen 'assumed a patriotic, activist character never before or since matched in feature films' (Kalisch and Kalisch 1982b: 608). Here, with the need for nurses at its most acute, Hollywood produced what critic James Agee calls, 'Probably the most deadly accurate picture ever made of what war looks like through the lenses of a housewives' magazine romance' (Halliwell 1989: 934). Kalisch and Kalisch view this film, **So Proudly We Hail** (1943) as Hollywood's 'greatest tribute to the nursing profession'. Apart from being one of the top money makers of the year and academy award nominated, the Kalischs find the image overwhelmingly positive; several beautiful young nurses display a great measure of heroism, self-sacrifice and stamina as they battle overwhelming odds that culminate in the largest military surrender of troops in American history. The film emphasises their professional work and the esprit d'corps that characterises their relationships with each other.

At the end of this period of their analysis, the point at which my analysis of British films begins, Kalisch and Kalisch see the professional image of nursing emerging as a valuable one, with a set of requirements and standards for its practitioners. Nurse characters retained their romantic functions, but not to the exclusion of other activities. To quote their conclusions,

‘in this ‘golden age’ of nursing films, women appeared able to practice nursing whilst pursuing personal lives. Even if marriage spelt the end of a nursing career, the career itself had mattered to these young women who recognised the value of their own contribution’ (1982b: 609).

This ‘golden age’ of nursing films identified by Kalisch and Kalisch belongs to an era of cinema when women regularly formed more than fifty percent of the audience for popular films, an era that Hollywood responded to and nurtured by producing films that would appeal to the female audience. Often referred to by critics and film scholars rather disparagingly as ‘women’s pictures’, these films were crossed and informed by numerous genres, but always had as their defining characteristic a central character of narrative agency who was a woman. The nearest a Hollywood film gets to depicting a female point of view of the world is when this central character, around whom all the action of the film revolves, is female. As feminist film critics have pointed out and debated in recent years however, the Hollywood production system is so thoroughly saturated with masculine values and ideals at all levels of the filmmaking process, that when it produces a female view of the world, that view is inevitably informed by male ideas and fantasies about women. Even when the director is a woman (in Hollywood, this has always been a rarity), the generic constraints of mass film production and the need to compete with men in the system

tend to mitigate against films which could be said to produce a viewpoint that is in any way radically different to the institutional status quo. Nonetheless, as Haskell (1974) points out, the 1930s were marked by the comparatively large numbers of women screenwriters employed by the studios, and many of them scripted women's pictures. It is therefore somewhat surprising to note that out of the first group of films mentioned by Kalisch and Kalisch, only one of them, **The White Parade**, is from a novel written by a woman and also has a woman on the screenwriting team. Films about nurses in this era seem to be based on stories and scripts written by men, a situation that was reversed in Britain in spite of the fact that there were fewer women overall working as scriptwriters.

Both the women's picture as a genre and the female audience begin to decline from 1950s on, for reasons that will be considered in some detail in part 3 below. What it is important to note here are two contextual factors that clearly affected the image of the nurse on the big screen during this period: the enforcement of the production code, which effectively banned the development of 'the naughty nurse' image, and a cinema audience in which women were consistently in the majority and had to be catered for. The combination of these two factors in the context of depression America changed the image of nursing from one which either re-presented the nurse as an icon of mythical womanhood or of sexual titillation and fantasy, to one where it was possible to practice nursing and enjoy a personal life as well.

**In From Reverence to Rape: The Treatment of Women in the Movies** Molly Haskell points out that,

'central to the woman's film is the notion of middle-classness, not just as an economic status, but as a state of mind and a relatively rigid moral code...Confronted by a range of options so limited she might as well inhabit a cell (the housewife) is dependent for her well-being and 'fulfilment' on institutions - marriage, motherhood - that by translating the word 'woman' into 'wife' and 'mother', end her independent identity' (Haskell 1973: 159/160).

Arguably, by 'marrying' nursing, a woman who became a nurse is equally dependent on institutional constraints, since the division of labour in health care, as many commentators have pointed out, echoes that of the normative ideal of the middle-class family with the doctor as patriarch, the nurse as mother and the patient as child (Garmanikow 1978, Muff 1982b).

Within American films about nursing in this period, the rigid moral code enforced on Hollywood by the Production Code tends to polarise female characters into 'good women' and 'bad girls'. Unlike in films of the 'twenties, where it was possible for a 'bad girl' to redeem herself by becoming a nurse, in the 'thirties nurses on the screen tend to polarise into 'good' and 'bad' types. Karpf (1988) points out the juxtaposition in **Vigil in the Night** (1940) between the Good Nurse and the Bad Nurse; badness amounts to neglecting a patient to satisfy ones own needs, in this case, making a cup of tea whilst caring for a sick child, with the result that the child dies. For this omission of duty, the Bad Nurse, whilst nursing another child with smallpox, contracts the disease herself and dies. Throughout the film, all the negative and critical comments about nursing are made by the Bad Nurse. The Good Nurse

is rewarded with a doctor partner and is given the final lines of the film, 'We're here to serve, and if we do it well, we find pleasure, freedom, perfect freedom...' The moral message of the film is clear; the wages of sin (in this case, the sin of putting one's own needs before one's duty) is death; it is a woman's duty to serve others, both in the literal sense of performing services, and in the abstract sense of serving particular ideas, beliefs and values. Only through willing and obedient self-sacrifice and service can a woman hope to find happiness and fulfilment. Like Haskell's masochistic American housewife, who is dependent on the institution of marriage for her identity, these women need the institutional context of nursing in order to function as characters.

In the 1920s, nurse characters had an iconic quality, embodying an essentially good, pure and untarnished femininity that set them apart from other female characters. This sign had the religious connotations of vocation and calling that were a part of nursing's mythic status. By the end of the 'thirties, films were showing that it was possible for ordinary women to achieve that status but that it involved, as Kalisch and Kalisch point out, a great deal of self sacrifice and determination. This is exactly the kind of sentiment that might be expected at a time when women were needed for nursing in ever greater numbers as the threat of war became reality, the Hollywood fiction factory serving patriarchal capitalism's hegemonic needs for women's low paid labour.

Karpf notes that the release of *Vigil in the Night* in Britain came soon after an attempt to enhance the conditions, training and pay of nurses, and 'had the flavour

of a recruitment drive' (Karpf 1988: 209). In British films about nursing, the flavour of recruitment is a strong one in the immediate post-war period, as the subsequent analysis will show. British film products in the 'forties tended to fall into two main categories, categories that were labelled at the time by British producer Michael Balcon as 'realism and tinsel'. Robert Murphy uses Balcon's categories to examine the relationship between cinema and society, pointing out that the 'forties are considered by many film scholars to be the 'golden age' of British cinema not so much because of the numbers of films produced, but because of their realist aesthetics and their concentration on issues that particularly pertain to the British way of life (Murphy 1989). In British cinema history, this legacy of a uniquely British style has traditionally been traced back to the documentary movement of the 1930s, and in particular to one man, John Grierson, who regarded cinema in much the same way that Lord Reith regarded British Broadcasting; that is, its function was to inform, educate and entertain, with the emphasis much more on informing and educating than entertaining. Film critics like Dilys Powell and Roger Manvell and film producers like Michael Balcon welcomed the realist aesthetic as a progressive force that would 'wean people away from their dependence on unhealthy fantasies and help them to become more worthy and responsible citizens' (Murphy 1989: 1). There was the sense of both a moral and a political crusade attached to the realist film, a crusade that had a class based dislike and disapproval of what was then regarded as 'the vulgarity and crudity' of much popular culture. Other producers (but few critics) argued that what the public needed and wanted were escapist films which had nothing to do with the horrors and realities of war. Hence, the realism and tinsel metaphor - with films featuring nurses falling solidly into the 'realism' side of the divide, even

though that realism now feels distinctly stodgy and artificial.

The nursing profession was keen to boast of and maintain its middle-class credentials throughout this period, as it had in earlier decades. Throughout the 1930s, the professional wing of nursing under the auspices of the College of Nursing had tried to unite the different nursing factions, fighting a hard battle with the municipal hospitals and the trade unions. Central to their philosophy was the idea of professional service, a 'no-strike' stance that was the cornerstone of the College's claim to professional rather than trade union status, as I discuss in more detail in Chapter 2. The elite who ran nursing during this period, in the main the matrons of the powerful London voluntary hospitals attached to university schools of medicine, tended to call the tune in terms of promoting the public image of nursing. It therefore comes as no surprise to find representatives of this small elite acting in an advisory capacity to filmmakers wanting to depict nursing on the big screen. The combination of realist filmmaking strategies, with their tendency to portray a rather stuffy middle-class view of the world, and the advice of those who sought every opportunity to reify their ideal of nursing as service and self sacrifice produced films that had the specific intention of boosting nursing morale and raising the levels of recruitment.

Throughout the war-time period, documentary realism worked hand in hand with official propaganda to produce films that supported the war effort. In the 1930s there had been strict moral and political censorship of films exercised by the British Board of Film Censors, controls that in war-time were changed and supplemented by the

Ministry of Information who both advised and proposed relevant filmic subjects. It is not surprising to find films featuring nurses amongst this group, made not so much for entertainment but to inform and educate the general public about nursing training in an attempt to boost recruitment and alleviate the acute shortage of labour.

As I discuss in more detail in Chapter 3, the writer Monica Dickens had considerable influence on the image of nursing at this time. Her popular autobiographical novel **One Pair of Feet** (1941) which tells of her war time experiences as a volunteer nurse, was used as the basis for a war time recruitment film, **The Lamp Still Burns** (GB 1943). The films' nursing advisor was the matron of a major teaching hospital, the London, and like a number of feature films produced in war-time Britain, this one was funded by government money. The opening credit sequence, presented against a background featuring a statue of Florence Nightingale with a suitably classical musical score, announces the films' worthy intentions: 'A tribute to all those who nurse made with the assistance and collaboration of the Ministry of Health'.

What is surprising however is how little the class barriers in **The Lamp Still Burns** have shifted or changed in the interests of reaching a wider audience. In **Millions Like Us** (GB 1943), the aspiring working-class heroine (sic) Celia dreams of becoming a nurse whilst she awaits her call-up, but ends up being sent to an aircraft factory. Throughout the 1940s and into the early 50s, there is no depiction of a working-class girl as a nurse on the big screen. In spite of the recruitment shortage, and the fact that nursing's main pool of labour was drawn from shop girls and low grade clerks, (Athlone Committee 1939, Maggs 1983) the nursing heroine of **The**



**Lamp Still Burns** is a middle-class architect who gives up her profession and business partnership to train as a nurse. The underlying message of this film seems to be that there is more personal satisfaction to be gained from the traditional 'womanly' work of caring for the sick than entering professions that were offering new opportunities to women such as architecture. It is difficult to envisage how the leading character Hilary might have offered a point of identification or even recognition for the majority of women in the cinema audience.

In this film, nursing work is portrayed as constant drudgery - Hilary spends more time spent in the sluice scrubbing dirty bedpans and equipment than feeding or caring for patients. As is usual in nursing films, the patients are all men, many of them working-class. The difficulties of showing a middle-class woman serving working-class women tend to be avoided by omission. In this sense, the film depicts a classically 'Nightingalish' image of nursing, which displaces class and gender difference through the use of the 'angel' image.

**The Lamp Still Burns** is an interesting depiction of hospital and nursing life before the introduction of the National Health Service and the changes wrought by the nationalisation of nursing. There is a fair amount of debate within the film about the role of women in society, much of it centring on the relationship between nursing and marriage. Hilary is befriended by Christine, an Irish staff nurse, who makes it clear that she has decided to marry out of economic necessity because she wants a home of her own, rather than for romantic reasons. A qualified nurse's wages were insufficient for an independent life; all the nurses live in the female community of the

nurses home, and the difficulties they face because they have dedicated themselves to a life of service are pointed out on numerous occasions. Against this background, Hilary stands out as the 'new woman', the nurse of the future, who wants to have it all - a home, a family and her career.

Stylistically, **The Lamp Still Burns** has many of the features that distinguish British films of this period from their Hollywood counterparts. The film looks like a studio production, with each shot carefully measured and lit but displays no expressive overtones in the lighting style or in the *mise-en-scene*. Similarly, the acting is taut and underplayed, expressive close-ups are avoided and little use is made of musical underscore to enhance the emotional intensity of the action. This tends to emphasise the spoken word as the supplier of the film's meaning, giving it a didactic quality. We are being told and instructed (and sometimes uplifted) by the dialogue, rather than emotionally swept along by the power of the image and the music. Nonetheless, Rosamund John's character is convincing. Her determination to get what she wants, and to change the training system in the process, is an indication of changing attitudes about women's public role as nurses and their private role as wives. It is an admission that these spheres are not necessarily mutually exclusive for women, although both are framed within a bourgeois liberal humanist ideal of service.

### **The Early 1950s.**

Striking in its similarities to **The Lamp Still Burns** is a film produced in 1951 by the Crown Film Unit for the Ministry of Information, **Life in Her Hands**. Although a fictional film with a screenplay co-written by Monica Dickens, it was billed in the

publicity as a documentary of nursing life. Produced specifically with the aim of recruiting women to nursing, the film was distributed on all the major cinema circuits. **Monthly Film Bulletin** described the film as 'combining impersonal information with a personal fictional story' (210, 18: 301).

The central protagonist Ann has some similarities to Hilary in **The Lamp Still Burns**. Like Hilary, she is older than the usual age of entry to nurse training, arriving at her decision after her husband's death in a car crash. As the driver of the car, she feels guilty and responsible for the accident; the 'fictional' content of the film is the story of her coming to terms with her feelings of guilt. Also like Hilary, Ann is from a very middle-class background, and is similarly warned by her family and friends of the long and difficult training she will have to undertake to be a nurse. Unlike Hilary however, Anne is deemed to have a vocation by the Sister Tutor. She is a 'born' nurse, not someone who merely wants to do a useful worthwhile job. The vocational element is much stronger in this film, in part signified by the nurses uniforms with their flowing, veil like caps. The overall impression continues to be one of a community of women living a narrowly segregated life under a strict authoritarian regime.

The realist style of presentation earned this film its documentary label, but the scenes of hospital life are clearly careful re-constructions of the actuality they represent. The 'fictional' sections of the narrative, which depict Anne's family life away from the hospital, are awkward, artificial and unconvincing. Considering the film has been made with the sole intention of informing viewers about nursing work and has no

romantic or other narrative interest, depiction of the work lacks detail. Only one sequence stands out, a montage that focuses on Anne's hands and facial expressions as she performs a number of routine nursing tasks. The tightly shot and edited montage emphasises hand/eye co-ordination and concentration, creating an impression of skill and dexterity in the nursing process. The patients on whom these tasks are performed however are largely absent as participants, serving as background for the nursing drama that is performed on and around them. Again, no female patients are featured and the working-class male patients are infantilised, appearing as rather mischievous but otherwise harmless children. Other nursing characters veer towards caricature; one sister is obsessed with weighing tea to check if the night nurses are using too much. Another, large chested and formal, warns her patients, 'You'll be dead before Christmas if you don't do what I tell you'. The dialogue in much of the film seems artificial, perhaps because too much emphasis is placed on presenting information at the expense of character development and plot.

In a personal telephone conversation with Miss H, former Sister Tutor in charge of nurse training at the old Liverpool Royal Infirmary during this period, I asked her if she thought films like **Life in Her Hands** influenced nurse recruitment in any way. Her considered opinion was that these films did little to encourage girls into nursing; she thought that Hollywood style films featuring famous nursing heroines such as Edith Cavell and Florence Nightingale were far more influential.

By the mid 1950s, Anna Neagle had come to epitomise for professional nursing the vocational ideal and heroic commitment to the profession that many nurses sought to

promote. In an article published in the **Nursing Mirror** (October 1958), shortly after her portrayal of the Matron in **No Time for Tears** (GB 1957) Neagle claimed that ‘the portrayal of nurses has given me great personal happiness, and I am indeed gratified if the nursing profession has found my portrayals satisfying’. Neagle played Florence Nightingale in the only British biopic of her life, **Lady with the Lamp** (GB 1951), directed by her husband Herbert Wilcox. By this time, the duo of actress wife and director husband were well established as makers of popular melodrama about the lives and loves of the aristocracy. Experts in patriotic nostalgia, in the 1930s they had made films like **Victoria the Great** and **Sixty Glorious Years** with Neagle as Queen Victoria in the starring roles. By the 1940s, Neagle was one of the top British stars at the box office along with Margaret Lockwood, Phyllis Calvert, Celia Johnson and Ann Todd. She had accrued a classy ‘star personae’ by the time she came to play Nightingale. Star personae is defined by Thumim as a particular set of audience expectations about an actor derived from previous performances, fan magazines, interviews and other public appearances (Thumim 1992: 48-56). Neagle’s personae was that of an upper-class English lady, a role that she played in her ‘private’ life as well as on the screen.

It is this personae that Neagle brings to the screen story of Nightingale’s life in a worthy depiction that attempts to describe not only her experiences in the Crimea, but also her skills as an administrator and her romantic and business attachments to the men who assisted her in her aims and ambitions. The film has all the marks of an expensive quality production, with a lavish *mise-en-scene* set in stately homes and large numbers of extras. Considerable pains were taken to construct a historically

accurate biography, no doubt partly in response to the Hollywood version of Nightingale's life, **The White Angel** (1936), but the film still tends to lapse into sentimentality, particularly in the scenes where Nightingale is tending the injured soldiers at Scutari. Some emphasis is placed on Nightingale's dealings with the 'drunkards and prostitutes' who are the tenders of the sick until her programme of reform, thereby substantiating the professional image of nursing as a career for well bred middle and upper-class women.

Unlike Hollywood's image of Florence Nightingale, the British biopic attempts to present Nightingale's work throughout her long life. The film also aspires to 'documentary truth' in its extensive use of location and attention to period detail. **The White Angel** presents Nightingale as an iconic figure, as the title of the film suggests; the image was clearly tailored to suit prevailing notions of sacrifice in depictions of 'thirties womanhood. Archetypal images of the nurse as mother, seductress and nun are merged iconographically in the *mise-en-scene* of the film through the use of lighting, costume and the placing of Nightingale in the film frame. Her decision to nurse, for example, is presented as sudden and forceful, like a religious conversion. Nightingale (played by Kay Francis, an American actress with a 'classy' personae similar to Neagle's) is dressed completely in white, with a dress and veil that are both bridal and religious in their connotations. She announces her decision from a chair that looks like a throne, after a scene where she has expressed a yearning to be like Queen Victoria so that she could do a man's work and express a man's point of view (Hudson Jones 1988: 226). Visually placed as a queen on a throne, in her white robes she presents an icon of femininity that encapsulates

sacrificial power.

The only scenes that achieve any thing like this kind of visual effect in **Lady with the Lamp** are, predictably, those where Nightingale walks amongst the sick with her lamp, but even here iconic effect is achieved through the signifying power of prior knowledge and previous associations rather than through the *mise-en-scene*. In essence, the film conveys a worthy attitude to its subject that fails to re-kindle the spirit that must have inspired Nightingale's contemporary admirers and supporters. This is in part the result of a narrative that focuses on obtaining money, which in retrospect appears to comment on contemporary changes brought about by the newly introduced nationalised health service. In their attempt to portray a less idealised and less mythologised portrait of Nightingale's life, the filmmakers do little to disturb prevailing notions; the film, as a fictional representation, is all the poorer because of this.

Finally, in conclusion to this cycle of films that instruct and educate about nursing, mention must be made of **White Corridors** (GB 1951), although it is primarily a film about a hospital and, unusually for the time, has a female doctor as its principle character. The film was adapted for the screen by two female screenwriters, Jan Read and Pat Jackson, from the novel **Yeoman's Hospital** by Helen Ashton. Stylistically, the film occupies an interesting space between the 'social problem' films of the 1940s, which attempted to realistically portray working-class life, and the later 'Free Cinema' films, which extended the concept of a realist tradition in British cinema through their extensive use of location shooting. **White Corridors** makes

considerable use of location, setting the story against the backdrop of a provincial northern town which gives the film an aura of 'authenticity' missing in earlier depictions of hospital life. Attention has been paid to depicting patients as characters from the town, placing the hospital within the broader context of the community it serves and cares for. The narrative trajectory of the film tells the story of an ambitious young doctor who wishes to work in a prestigious London hospital in order to further her medical career. This desire is complicated through her romantic attachment to a committed medical researcher, who wants to remain where he is. Although the doctors' professional and romantic lives form the backbone of the plot, with the issue of the woman's commitment to career and family values clearly foregrounded, the film has a number of other significant characters who play major roles, two of whom are nurses. One of these is a young trainee, the other a more experienced and slightly older trained (staff) nurse.

Education, information and entertainment are well-balanced in this film, with the educational/informational emphasis not so much on the details of nursing or medicine but on the broader context of the national health service. Unequivocal in its support of the value of the NHS, the film enacts several of the bureaucratic and procedural changes that have been introduced and debates how to prioritise the meagre government budget allocation. This attention to the detail of contemporary debate extends to the portrayal of the nursing staff and their internal relationships with the rest of the hospital staff, an aspect of nursing life missing from both **The Lamp Still Burns** and **Life in Her Hands**, where the only other hospital workers represented are doctors. In this film, the class relationships between nurses, doctors and other



workers form a clear hierarchy, with the nursing staff occupying a position somewhere in the middle. Although well-spoken, the nurses are less pretentiously middle-class than in other films; their comparatively inferior status is foregrounded in relation to the high status middle-class women who are either doctors themselves or engaged to doctors. One of the sub-plots of the film portrays the romance between a young doctor and a staff nurse, telling the story through the gossip of nurses who are cleaning the sluice. Another tells of the initiation of a new nursing recruit into hospital life, portraying her fear of coping with death and the anxiety of dressing the facial wounds of a man who has been hideously disfigured in an accident.

The nurses good naturedly complain about the damage done to their hands by endless washing up in the sluice and the kitchen, and the damage done to their figures by an endless diet of suet pudding and stodge. Although the patients (both male and female) are treated as children by the nurses and class differences between them are apparent, patients are shown as characters who are sometimes co-operative and good natured, but can equally well be grumpy and difficult. The sisters on the whole command respect because of the knowledge they have about patterns of disease and are not mocked as petty authoritarians. Matron is a level-headed administrator who tries to improve the lot of her staff amidst competing claims on the hospital's tiny budget. Running a hospital is shown to require a complex set of skills and judgements shared between the medical and nursing staff and their lay administrators.

Fraternisation between the medical and nursing staff is not permitted in working

hours, and one nurse is sacked as a result of such a liaison. In a heated exchange with the Matron, she exclaims, 'You have no right to interfere in my private life...I suppose you want us all to grow into frustrated spinsters'. The Matron, a kindly woman, is visibly shaken and upset by this and has to make an effort to pull herself together. Nurses in this film are portrayed as human characters rather than embodiments of iconic ideals. Their work is shown to be hard but rewarding, and the sisters in particular are shown to have repositories of knowledge that doctors draw on and use in their work. Different aspects of the various jobs in nursing are clearly depicted so that, unlike in other films of the time, an audience is informed not so much about nursing tasks (which are to some degree obvious) but about nursing skills - skills learnt through clinical observation and nursing practice.

In conclusion then, this group of films tends to present professional nursing's reified ideal image in a style which claimed to present an authentic view of the world to the cinema audience. Somewhat surprisingly, it is the totally fictional **White Corridors** which now seems to re-present the clearest picture of nursing life, but even that was criticised at the time for its shallow depiction of characters although it had 'a quality of professionalism rarely seen in British films' (**Monthly Film Bulletin** 210, 18: 294).

The nursing image on offer to the female audience in most of these films is one of a youthful, girlish eagerness to commit oneself to a life of duty, counting it as a privilege to serve the great and noble profession of nursing. The young self-sacrificing 'angel' is juxtapositioned with her older, more experienced counterpoint,

the 'battleaxe' who presents an imposing image of matriarchal authority. It is hard to avoid the conclusion that becoming a nurse in these films heralds the possibility of a personal transition from 'angel' to battleaxe, an anxiety that some of the nurses interviewed in Chapter 3 remember experiencing very strongly. 'Battleaxes' were women to both fear and respect; many of them had dedicated their lives to nursing in the aftermath of a first world war which wiped out a whole generation of young men. In one sense, these women embodied the image of nursing as a vocation found in Victorian popular fiction, women who had turned to nursing as a means of displacing their thwarted sexual desires. During the second world war and its immediate aftermath, this image might have had some resonance; Anne, for example in **Life in Her Hands** is a widow narratively placed as in search of a substitution for her loss.

Thumin points out that nursing figures as one of the few diegetically significant occupations amongst female characters in films of this period, only outstripped by the numbers of maids and performers of various kinds. Even then, nurses only feature in four popular films of the mid 1940s, ten in the mid 'fifties with this number down to zero by the mid 'sixties. In a comparative analysis of women's occupations featured in women's magazines, she notes that the medical and caring professions are mentioned more than any other category, with nursing featuring as the most important, but not the only, group. She finishes by saying,

'It is difficult to avoid the conclusion that the routine presentation of women in popular cinema during the post-war period severely limited their career possibilities. Female audience members were likely to find their horizons more broadened in contemporary women's magazines than they were among

the images of their celluloid sisters on the screen' (1992: 111-112).

It has to be concluded then that there is little evidence that feature films contributed markedly to public perceptions of nurses and nursing throughout this period, in spite of the profession's and the government's belief that this was the case, and their consequent attempts to use the film medium as a vehicle for recruitment.

### **The books.**

From the mid 'forties onwards, nursing career books for girls grew rapidly in their popularity. Far more successful as enduring cultural artifacts about nurses and nursing life than the films of this period, the two most popular series, the **Sue Barton** and **Cherry Ames** books can still be found on the shelves of many local libraries, and continue to be borrowed regularly. There can be no clearer indication of their prolonged and continuing effect on the hearts and minds of young women. For books that were written for a popular juvenile audience some fifty years ago, they seem to have achieved the kind of popularity that is in some ways equivalent to that of the well-known writers of adult mysteries and romances. What then are the enduring qualities of these books? Why have they been so widely read by at least two post-war generations of readers? Is it something to do with their narrative formats, which are similar to those of popular romance and mystery novels, or something to do with the content of the stories and their images of nursing life?

Re-reading the **Sue Barton** books after a period of some twenty-five years, I am struck by two immediate reactions before reading more than a couple of pages. The

first is how familiar the stories seem to be (even though I do not think I ever read either **Sue Barton, Superintendent Nurse** or **Sue Barton, Staff Nurse**...I was a committed **Cherry Ames** fan!). The second is how like popular medical romance novels they are. Re-reading **Cherry Ames**, I remember that I preferred these books because they were primarily mystery stories with 'investigative thriller' narratives. What I did not remember (if I ever knew) about either series was that they were written by North American authors, and are about North American nurses and nursing. The female 'heroines' of these novels have that peculiar mix of characteristics which I now see as redolent of so much American writing for girls of that time - a combination of an adventuring, pioneering spirit with a determination to get what you want, yet with a preparedness to serve others and find it a pleasurable, enjoyable task.

The writer of the **Sue Barton** series, Helen Dore Boylston, was herself a nurse for many years. She began her training at the age of eighteen at the Massachusetts General Hospital in Boston in 1913. By the end of the first world war, she was a member of the Harvard medical unit for duty overseas with the British Expeditionary Forces. She later joined the American Red Cross, serving for two years in Poland and the Balkans before returning home to the Massachusetts General Hospital, where she taught nose and throat anaesthesia. It was around this time that a writer friend read her war diary and sent it to the **Atlantic Monthly**, where it was published in serial form. This was the beginning of a new career as a professional writer. The first of the **Sue Barton** series was published in 1939, the rest following at regular intervals until the early 1950s. It has become one of the most popular 'nursing'

series in the world (according to the publishers, whose assessment may be optimistic). Nevertheless, the books certainly have endured. Not only are they still to be found on the shelves of my local library, but they are still on sale in some bookshops even though they are currently out of print.

In spite of my own preference for the **Cherry Ames** series, these books are now less visible than the **Sue Barton** series, and have not been re-printed in Britain since the 1960s, when they were brought out in hard back. There is less information available about the writers, Helen Wells and Julie Tatham, who between them produced at least sixteen books between the early 1940s and the late 50s. Even so, these books were undoubtedly popular - **Cherry Ames Flight Nurse** was reprinted five times between 1956 and 1963. As a contribution to this project, several friends donated me copies which were first given to them in the early 1960s.

What interests me in these texts is their ideological function in relation to girls who are on the threshold of 'becoming women'. I can remember at the time I was reading these books that 'becoming a woman' was much at the forefront of my mind. My mother's only guidance in this matter was to give me a small pamphlet with a picture of a young woman holding a baby inscribed on the front. It was called, appropriately enough, '**You're Becoming a Woman**', and described with the aid of diagrams the physical processes and changes in bodily appearance that would transform me from adolescent girl to mature woman. But what sort of woman was I to become? In the period before my life became dominated by an over-riding interest in boys, I read a great many mystery and romance books. For me, these books were landscapes of

possibilities, maps to guide me through an unknown terrain. This aspect of pre-teenage reading has recently been analysed by feminist researchers like Linda Christian-Smith, who claims that this kind of cultural product presents young readers with imaginative resolutions to the relations between the sexes and are productive of certain subject positions for them (Christian-Smith, 1988).

Christian-Smith's study of adolescent reading does not however encompass career novels like the **Sue Barton** books, ostensibly about work, about the material world, which none-the-less use similar tropes and narrative formats to teenage romance texts. I want to argue that the combination of career and romance in these texts about nursing works to sustain the division of labour in health care, re-enforcing what Gamarnikow (1978) has identified as the patriarchal familial structures inscribed in the relationship between medicine and nursing. Becoming a nurse in these books is about taking on a particular feminine identity, one that aligns nursing skills with wifely skills. Like other medical romance series, such as those produced by Mills and Boon, the **Sue Barton** books in particular link working life and personal life through relationships with medical men. Because the heroines of these books invariably marry doctors, the difference between work in the public sphere as a nurse and work in the private sphere as a wife is subsumed through the discourse of heterosexual relationships. The hospital becomes a macrocosm of home life, with doctors as 'fathers', nurses as 'wives' and 'mothers' and patients as 'children'.

To illustrate this point, I would like to use an example from **Sue Barton: Staff Nurse**. This is the sixth book in the series, and was written in 1950. Bored at home

with her three small children, and feeling that she is wasting her valuable skills, Sue Barton, now married to the head of a small country hospital Dr. William Barry, decides to return to work. This causes some consternation amongst the staff on the ward she is allocated to, for not only is she the boss's wife but she was also formerly nurse-in-charge of the hospital and had established the training school for student nurses. Sue's best friend Kit, who trained with her and has since been her inseparable companion, is now superintendent of nurses. Between them, Sue and Kit are 'ideal types' of nurse, each of them representing the particular aptitudes and skills that different areas of nursing work demand. Whereas Sue is foregrounded as a practical nurse who excels in her contact with patients, Kit is presented as a skilled manager who is responsible for the training and discipline of junior nursing staff. The medical staff however are totally outside her jurisdiction. One result of this separation of duties and responsibilities is that a young student nurse has to be punished for a doctor's misdemeanour even though she is totally powerless in the situation and Kit knows this is unfair. The incident centres around a doctor/nurse romantic entanglement between a soon to be qualified student nurse and her doctor boyfriend. Messing about in the hospital dining room, he picks her up and carries her off. Although the powerlessness of her situation is obvious (we already know Frank to be considerably bigger and taller than her), nursing management feel bound to seriously punish the nurse with suspension because she has set a bad example to other students. Not to do so might lead to a breakdown of hospital discipline amongst 'irresponsible students', who would see this as a green light for misdemeanours with the medical staff. Placed in the position of having to treat a student unfairly, our resourceful 'girls' Kit and Sue decide to solve the problem by playing a trick on the



doctor. His 'violently masterful' response to their challenge and subsequent proposal of marriage to the student is exactly the response Kit and Sue expect. An institutional problem, the disciplining of doctors to respect their nursing colleagues as equals in the public sphere of work, is resolved by emotional manipulation. Kit knows that she cannot 'punish' the doctor, she has no power to do so, and to complain to the medical hierarchy about such a display of boyish high spirits would only demean her. She uses subterfuge (her feminine wiles!) to get what she wants, rather than any kind of public, political action that would disturb the existing power relations. Nursing's subordination to medical power is naturalised in the narrative, accepted and circumvented, leaving the structural relationships between nurses and doctors intact.

In these books, the public and potentially political sphere of hospital work is articulated as the shared personal, space of a small tightly knit group of female friends. Initiation into the nursing profession is an initiation into a small group or cohort which occupies a particular position within a rigid professional hierarchy. A major part of this initiation is the wearing of the nurses uniform, in itself a process that exposes a private world of unwritten professional rules and codes, many of which are expressed in the complex signification of the nursing uniform itself. There is a clear binary opposition posed between the public presentation of the private self in the everyday world and the private presentation of the public self through wearing the nursing uniform. In the public presentations of the self, we are given detailed descriptions of the clothes and make-up that Sue and her friends select for every social occasion, whether a walk in the country or a night at the theatre. As well as demonstrating how to dress as a young middle-class single woman, the reader learns

about lifestyle and attitudes. In the public sphere of work, attitudes to the role of the professional nurse are judged by personal appearance. Those defined as problems wear their uniform incorrectly, their hair in the wrong style or are described as 'untidy' and 'too casual'. The way these young women look is taken axiomatically to signify their attitude to their work and to the nursing profession.

This pre-occupation with appearances extends to fetishistic descriptions of the nurses' uniform,

'tiny crinoline cap with a black velvet band around a frilled base perched at a slight angle on smooth brown hair. White uniform, white shoes, white stockings and Eton collar were immaculate' (Dore Boylston 1942, this edition 1968: 9).

The uniform however is also a fashion item, the way the hat is worn at a particular angle negotiating the boundaries between nursing identity and the wider discourse of femininity as manifested in contemporary ideas about clothes and how to wear them. As Dorothy Smith (1988) so cogently points out, fashion images are articulated around other meanings of the feminine such as particular virtues and resistances. Femininity is a historically specific phenomenon whose articulations change over time. The nurses' uniform contains within its accoutrements traces of these changing virtues and resistances, inscribing on the bodies of those that wear it both the ghosts of nursing foremothers and the relationship of those ghosts to contemporary professional ideals.

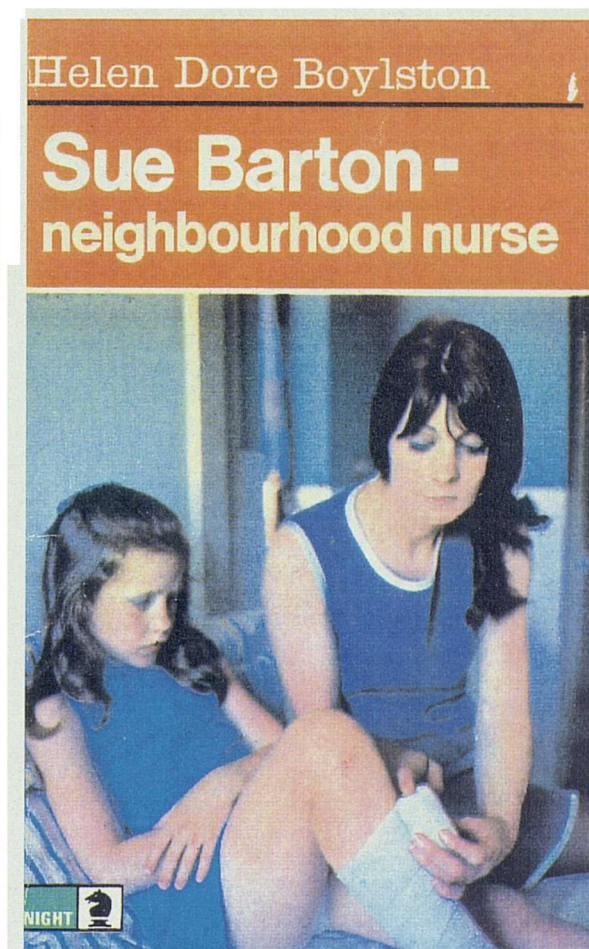
In the **Sue Barton** books, this foremother is indisputedly Nightingale, a British

nursing heroine, in spite of the American origins of the author. It is this emphasis on Nightingale and Nightingale values in nursing which enabled the books to become cross cultural artifacts. Direct references to Nightingale as well as veiled hints refer to a past that is never articulated in historical terms, creating an aura of mythic deification around the Nightingale image. To emphasise the point, in **Student Nurse**, Nightingale's presence is fully evoked through the memories of a very elderly patient who had served as a drummer boy in the Crimea. His memories of Nightingale as a 'lovely slim and gentle young thing' are a clear distortion of the known facts of history, but work at an emotive level in the novel, emphasising self-sacrifice even to the point of death. For young women reading these books, the potency of this martyred image is reinforced by the incident immediately following the encounter, where Sue almost dies in the effort to save a patient's life.

Descriptions of clothes in these texts, and of uniforms in particular, are heavily value laden. They carry within them the codes of a specific set of feminine values, and those values are re-articulated through the transforming process of putting on the uniform, and donning with it an ideal of professional tradition and identity. The student nurses in these stories are measured against this ideal, their success or failure as nurses depending on their ability to become more (or less) like the model nurses Sue and Kit, who are set up as complimentary opposites both in terms of their appearance 'types' (red head, brunette) and as working 'types' (practical skills, management skills). In addition, as readers we are constantly presented with little descriptive homilies that remind us of the personal qualities needed to be 'good' women and successful nurses:

‘...she had that gift, supposedly common to all good writers or actors of projecting herself into the interests and feelings of another person. It is a gift also common to good nurses, good friends - and good wives’ (Dore Boylston 1942, this edition 1968: 54).

The books function in part much as sentimental novels functioned in Victorian times, presenting moral messages of self abnegation to a readership on the threshold of womanhood, subjecting the reader to ideals of nursing and femininity which in the 50s recruitment literature are encapsulated in the word ‘service’ (Hallam, forthcoming, 1996). For Sue Barton however, nursing is not only a matter of serving but a way of living. The books present nursing as an ongoing, developing career that mirrors the development of her romance, marriage and the birth and growth of her children. In her career, there is no clear distinction between work and personal life, only an all-encompassing narrative that weaves her life into a seamless whole. This lack of separation creates an identity that is unproblematic and fixed, a white heterosexual middle-class ideal against which all women who are different in some way are judged as deviant or ‘other’. Race is an almost invisible absence, only presented as the peculiar characteristics of certain working-class patients from the slums. Patients throughout the books are treated much in the way that Sue treats her children, emphasising the ‘innate’ womanliness of nursing work. As career novels for girls, readers are subjected to an image of work against which they can measure themselves not in terms of intellect or ability, but in terms of how they look, what class they come from, and how they measure up to nursing’s feminine ideal.



*Plates 1 & 2: Sue Barton book covers, 1970s.*





*Plates 3 & 4: Sue Barton book covers, 1980s.*

These stories now seem to present a reactionary, old-fashioned view of what it means to be a working woman. Within the melding of the public and private discourse at this particular point in history, there is however some space for re-cuperation. In the 1940s and 'fifties, giving up work on marriage was virtually mandatory for most middle-class wives, but Sue Barton manages to combine marriage with a career, and through this juggling act perhaps symbolises the possibilities for those (young middle-class white women) becoming nurses in the future.

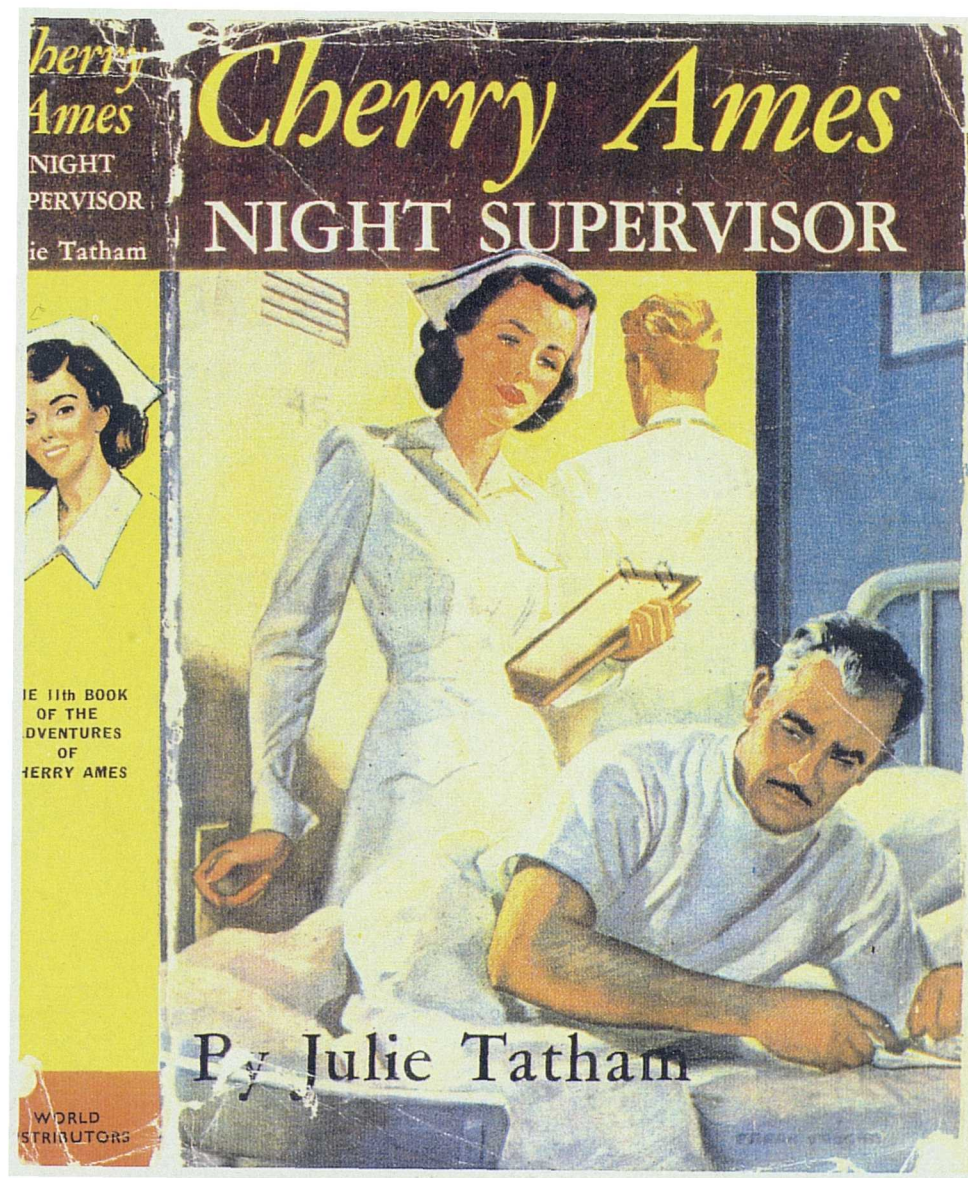
In a different way, the **Cherry Ames** stories also provide a model of nursing as a career that was perhaps more dynamic at the time than appears to be case now. As I said earlier, I much preferred these stories, perhaps because the image of nursing presented here is a much less restricted one, in the sense that there is less emphasis on notions of hierarchy and discipline and more on the range of possibilities inherent in the nursing situation itself. The titles of these books, rather than mapping out a career path in different fields of nursing work, present some eighteen venues for nursing, from hospitals to ships, mountains and the army. Structured as mysteries, where Cherry Ames always plays a leading role in solving the problem, the books seem to have more in common with the detective nurse movie series of the 1930s than with the **Sue Barton** books.

Articulations of the relationship between nursing and femininity are also rather different. Cherry Ames wears both powder and nail varnish on duty, in the **Barton** books a sign of lower-classness, but in these books a sign of middle-class sophistication. There is less detail about clothes and uniform, and much more about

the actual work that Cherry is doing; the job of nursing itself sounds interesting, rather than the role of the nurse as presented in the Barton books. In **Flight Nurse** for example, we are told that Cherry has had to learn to arrest haemorrhages, dress wounds, adjust splints, administer plasma and give shock treatment whilst flying at different altitudes and without a doctor present. There seems to be more reason in these texts for discipline and self-sacrifice, and descriptions of the work, although at times lapsing into sentimentality, do demonstrate a range of skills accompanied by both a caring nature and strength of mind. The investigative format, in a similar way to the detective nurse films, presents Cherry Ames as intelligent and able to act on her own initiative. Cherry was certainly the epitome of my young woman's dreams of the feminine ideal - beautiful, intelligent and adventurous, living a life where she was footloose and fancy free, much sought after by young men, but not in need of a male partner even in the closing pages of the book.

In other ways though, the image of femininity Cherry represents is still that of the good girl, someone who wants to please because pleasing others is the key to popularity, and therefore to happiness. Although she is resourceful and uses her own initiative, Cherry also unquestioningly obeys doctors' orders, and treats patients like naughty children when they break hospital rules. Nursing as a profession seems far less powerful than in the Barton books, perhaps because its contextual relations are described more. In the hospitals where Cherry works, doctors have the power to hire and fire the nursing staff. In **Cherry Ames, Night Supervisor**, although Cherry is in charge of the nursing staff, it is clear that she is employed by the chief medical officer who runs the hospital overall. Nursing is depicted as a job rather than a





*Plate 5: Cherry Ames dust jacket, 1960s.*

profession, a worthwhile and satisfying job, but one in which the notion of service is clearly limited to serving male doctors and male patients. The opportunities afforded by nursing training are those of travel and adventure, rather than a life of dedication to professional ideals and values.

Throughout the post war period and into the early 1950s, the fictional images of nursing available to the general public in Britain tended to emphasise the aims and ideals of professional nursing. In their different ways, these fictions re-articulated the notions of sacrifice that were so common in women's films of the 1930s and 1940s, emphasising that the vocational ideals of nursing were shifting to accommodate new ideas in society about the relationship between marriage and career. Whilst some fictions, like the **Cherry Ames** series, used nursing as a background for adventure stories and mysteries, many of them attempted realistic representations of nursing life that reified an ideal conception of the professional image of nursing during a period of rapid upheaval and change. The use of feature films to recruit women for nursing was complimented by a range of 16mm films that could be hired to show in schools, but whether any of these efforts of themselves increased recruitment levels seems unlikely. In a study that examined the effects of a recruitment film on the attitudes of school leavers towards nursing as a career, Jeffery (1950) concluded that there were no significant changes in attitudes as a result of the film, either in the immediate aftermath or six months later. Generally, there was a dislike of the sight of blood, sick people and suffering, leaving home, night duty, studying, discipline and hospital work. Those that wanted to nurse were mainly interested in nursing children, and had

some direct experience of hospitals through their relatives. This general antipathy towards nursing as a career led to a marked increase in the attempt to recruit nurses from overseas, an issue discussed in more depth in Chapter 2. Attitudes to nurses and nursing become much more ambivalent in cultural products from the mid 1950s on, particularly in films, and it is to the mid 1950s and early 1960s that I will now turn my attention.

### Part 3

#### Irreverence and romance: from the 1950s to the 1960s.

The reification of Nightingale values encapsulated in the nursing films of the early 1950s was followed by a rapid shift in style towards films which treated nursing characters as melodramatic heroines or as objects of parody and derision. The late 1950s and early 1960s saw a proliferation of British films about hospital life on the big screen. In particular, the popular and successful ‘**doctor**’ films followed the lives and loves of a newly qualified medic in a lighthearted look at the British medical establishment, and the ‘**Carry On**’ series found in hospital life an ideal location for lampooning the British establishment and its paternalistic values. Within the ‘carry on’ format in particular, nurses became an easy target for toilet humour as well as a generative source of it. Joan Sims’ depiction of a down to earth (working-class) nurse commenting, ‘What’s all this fuss about such a little thing then’, as she peers under the bedclothes on the pretext of preparing a male patient for theatre exemplifies the irreverent approach to nursing taken by these films. Nurses are no longer nice middle-class girls coolly detached from the bodily functions of their patients, but working women who talk in saucy sexual innuendos to their physically helpless charges. They are not the asexualised, virginal ‘nice’ girls of earlier films, but often pneumatic busty blondes (in the shape of Barbara Windsor in particular) who delight in causing ‘out of control’ physical responses in incumbent male patients. The image of professional nursing authority is perhaps the cruellest of all the stereotypes the films present, with Hattie Jacques frequently playing the frustrated matron or the

sister who is too old, too plain and too fat for sex. Whilst the younger nurses are allowed to have hearty sexual appetites as long as they are not too intelligent, for all other females sexual desire is shown as laughable and grotesque. Powerless in their ability to attract men, senior nurses in particular are depicted as puppets of the institution, petty tyrants with no real authority who play out their frustrations on powerless junior nurses and patients.

These filmic images stand in stark opposition to earlier ones, and can certainly be seen as derogatory of nursing values, but I would argue that situated as they are within a film genre that sets out to poke fun at Britishness, they follow in a music hall tradition of humour that places the ordinary working man in the position of mocking those who seek to order and control his life. Created to entertain the young male audience who formed the bedrock of cinema's clientele by the late 1950s, they mock not only the prudery of middle-class female sexuality, but the impotency of medical men as well. Their critique is clearly class based, aimed at both middle-class propriety and working-class mores. Within the ensemble playing of the regular cast, Kenneth Williams invariably plays the part of the chief medical officer as a middle-class sexual impotent, whilst working-class patients (particularly those played by Sid James) are always depicted as worldly wise and sexually voracious.

The hospital was a popular venue for **Carry On** films, no doubt because of its suitability as a setting for generating situation comedy based around bodily functions and sexuality. Much of the humour lies in the way in which the institution is unable to control the baser (or more animal) nature of human beings through its timetables,

regimes and regimentations. As Marion Jordan points out, the characters and the humour are those of the most demotic types of fiction - the comic postcard and the bar-room joke. The jokes are not only obscene, but they express a very masculine view of the world, where the castrating mother-in-law is always the wife's mother, sexual desirability (however much parodied) is most commonly female, sexual desire and potency most commonly male (Jordan 1983: 318).

The status of these films as popular (lower-class) entertainment has been reflected in the lack of serious consideration given to them in histories of the British cinema, even though they were the top box office grossers of their day. It is only in recent years that they have been acknowledged as part of a British cultural tradition that lampoons traditional class values and divisions. In relation to the medical establishment, they are the first sign of a public critique of medical power that questions the powerlessness of patients and their automatic reduction to infantile status. The films can be read as an early indication of the consumer critique of medical services which becomes much more pronounced in the 'seventies. The male working-class patients wreak havoc within the institution by refusing to obey orders, pointing out in the process how the sterile environment creates impotency amongst medical men and petty authoritarianism and sexual frustration amongst the nursing staff. In later films, such as **Carry On Doctor** (GB 1968), female patients appear on the screen as foils to their male counterparts, but the action is still centred on the antics of male patients, avoiding by omission the problem of how to generate humour for the predominantly male audience from female nurse to female patient encounters.

Amidst the light hearted capers of the ‘**doctor**’ films, and the lampooning of the ‘**Carry Ons**’, there were however a few films that took nursing explicitly as their subject matter. Three in particular stand out as significant explorations of nursing life: **The Feminine Touch** (1956) follows the training of five nurses at a major London teaching hospital, **No Time For Tears** (1957) explores the hospital nursing of sick children and **Twice Round the Daffodils** (1962) follows the progress of a group of patients in a long stay TB sanatorium.

The most noticeable change in **The Feminine Touch** and **No Time for Tears** from their ‘drama documentary’ predecessors is a tendency towards melodrama and sentimentality that is heightened by colour cinematography and high production values in the presentation of the filmed image. Concomitantly, the nursing workforce is more glamorous than at any other time on the British screen. The nurses’ uniform, with its belted waist and billowing apron, was ideally suited for subtle adaption towards the ‘New Look’ that became fashionable from the early ’fifties on. Featuring cone shaped breasts, boned bodices, tight waspish waists, long full skirts and pointed toed shoes with slim heels, the ‘New Look’ was a return of constricting fashion, of clothes that it was difficult to move around in very much. Read by some as a sign of a post-war nostalgic return to Edwardian values, ‘New Look’ fashion signified a return to ‘feminine values’, eschewing the ‘masculine’ tailored suits and smart ‘working girl’ clothes that had led fashion throughout the 1940s in favour of an abundance of soft flowing fabrics and dainty accessories. **The Feminine Touch** exemplifies how the ‘New Look’ is part of a wider discourse that re-situates women in the domestic sphere, even though women (and in particular, married women) were

recruited into the general workforce in increasing numbers from this period as Wilson (1980) points out. Although a film ostensibly about becoming a working woman, the articulations between fashion and femininity signify a contradictory attitude that places female nurses securely beside their male medical colleagues rather than at the bedside of their patients.

Following in the pattern set up by **The Gentle Sex** (GB 1943) which portrayed seven different 'types' of young women undergoing their war-time ATS training, **The Feminine Touch** tells the story of five young women becoming nurses and learning to accept each other's differences in the process. As in its forerunner, the differences dealt with by the five stereotypical trainees are articulated around notions of class and Britishness with 'Irishness', 'working-classness' and 'upper-classness' used to offset the 'norm' of white bourgeois Englishness encapsulated in the two leading characters. The five types can be summarised as the beautiful, naive blond (Susan), the sophisticated, wordily wise brunette (Pat), the plain ex-public school girl (Ann), the red-haired fiery Irish beauty (Maureen) and the rather untidy working-class girl from the East End of London (Liz). Needless to say, in line with the dominant trend of female stars in the 'fifties, the story focuses on the glamorous blonde Susan with the brunette Pat in a strong supporting role. Susan manages to exemplify the 'New Look' both in her uniform when on duty and in mufti when off, whereas Pat presents a more traditional '1940s' image of the career girl in her smart fitted suits. Although they are opposite 'types', as in the **Sue Barton** books, this does not stretch beyond superficial appearances; both women marry doctors, so obviating the need for any serious consideration of their nursing abilities or their career prospects, but Pat



marries an older man whilst still in training. Through this narrative device, the film publicly questions the restrictive rules and regulations surrounding the marriage of nurses during training but realist conventions demand that Pat gives up her career to care for her husband.

Where this film forms an interesting comparison with the earlier 'recruitment' information films however is in its actual depiction of nursing work. In this film, and in **No Time for Tears** which followed it a year later, nurses are seen less on the wards attending patients or in the sluices scrubbing the bedpans, and far more in the ward kitchens where they engage in preparing food, not only for patients but often primarily for the doctors. Furthermore, it is made clear that the nurses are feeding the doctors at some considerable risk to themselves, since the food they are using has been provided for the patients and they are stealing it. Consorting with the doctors and squabbling with other nurses over who should be privileged enough to feed them is a major nursing activity in these films, rather than interaction with the patients or any demonstration of nursing skills. In **The Feminine Touch**, a similar montage sequence to the one used in **Life in Her Hands** (1951) shows the busy-ness of nursing work depicted through a series of faces in close-up calling for a nurse, with patients intercut between sisters. All the faces and voices are female. In the narrative structure of the film however, it is the doctors who command nurse attention; senior nurses and patients are merely obstacles to junior nurses devoting their time to meeting their needs. Doctors are depicted doing many of the minor tasks for the patient that in earlier films had seemed to be the province of the nurse, and her role is diminished, confined to the kitchen and looking after the doctor. In

these films, nursing is shown as a suitable training for a woman's 'real' work in life, looking after her (doctor) husband and children. They depict a fantasy of femininity based on 'New Look' fashion and kitchen centred caring. Even their voices contribute to this domestic ideal, with shrill tones of little girl eagerness and close-ups of trembling lipped femininity contributing to the overall impression of soft focus vulnerability endorsed by technicolour film and high production values.

Although ostensibly offering a critique of nurse training and the harsh working conditions of student nurses, the vocational ideal is heavily emphasised. A stance on nursing issues is clearly articulated by the matron at several points in both films: that the deep happiness to be found in nursing is that of being of service. The book on which **The Feminine Touch** is based, **The Lamp is Heavy** by Sheila Mackay Russell, is critical of precisely this attitude of suffering servility, but **The Feminine Touch** is infused with this ethos. This is undoubtedly due to the influence of the film's nursing advisor, the matron of another famous London teaching hospital, and the screenwriter Monica Dickens who seem to have seen no incongruities in this move to a more romanticised and sentimental view of nursing life focused on doctor centred caring.

The only film that treats nursing work with the kind of matter- of-factness with which doctoring is treated throughout this period is, rather surprisingly, a low budget comedy and minor 'B' movie screen filler, **Twice Round the Daffodils**, (GB 1962). Made in black and white on what was clearly a minimal budget, this story of life in a TB sanatorium focuses on a mens' ward in the care of Catty, a nurse who is shown

to be more than capable of coping with her difficult patients, in both physical and psychological terms. Although tending towards the 'ministering angel' stereotype, Catty is shown to be neither a prudish asexualised virgin or a doctor's handmaiden. The nurses are shown to have a considerable degree of autonomy, only falling under the jurisdiction of a rather distant Matron. As well as coping with routine nursing tasks, they have to deal with many of the male patients' problems created by long term illness and hospital confinement, including anger, depression, and sexual frustration. There are no doctors depicted, although there are veiled references to their presence.

Against this positive picture however has to be set the fact that nurses in this film are set up as sexual spectacles for male viewing pleasure. At one point, a nurse loses her skirt, 'unknowingly' revealing the classic fantasy of frilly knickers, suspenders and stockings to the male patients hiding voyeuristically in the cupboard. The nurse revealed on the screen is no simplistic 'carry on' joke however, but the public depiction of a fantasy which gained increasing visibility throughout this period. As the movie industry successfully lobbied the boards of film censorship to relax their standards so that cinema could compete more effectively with its new leisure rival television, so more of women's clothes were removed on the screen to attract the male audience back to the cinema. Nurses suffered the same fate as other female characters, revealing shapely sexualised bodies beneath fetishised uniforms. Catty, as a ministering angel, manages to avoid this fate, although, predictably, she does end up at the close of the film engaged to one of her patients.

## Part 4

### Fascination and aspiration: the romantic ideal

From the mid 1950s to the mid 1960s, there were an unusually high number of films made which used a hospital environment as their background. Most of these films featured doctors in the leading roles, but there were also a substantial number of films which in some way profiled nursing. Medicine and nursing also began to feature heavily in other popular fictional genres, in particular in the romantic fictions of Mills and Boon, publishers specialising in the production of cheap, mass-produced paper backs for a primarily female readership. Within the histories of this form of fiction production, considerable attention has been paid to the concept of romance and how romance operates as pornography for women (Snitow, 1984). Several studies have attempted to examine the relationship between female desire, pleasure and romantic fiction, most recently and notably perhaps **Loving with a Vengeance** by Tania Modleski (1984) and **Reading the Romance** by Janice Radway (1984). Given the general attitude of critical disparagement towards this form of literature and its readership, feminists have been concerned with finding in the activity of reading a recuperative impulse, one that can be analysed as some form of resistance to dominant (patriarchal and capitalist) values. Here, the approach I use focuses on the underlying ideological assumptions of the texts, the ideas and images that writers - all of them women, many of them trained as nurses - were drawing on to engage their readers.

In my case study interviews with women who became nurses between 1950 and 1975,

In my case study interviews with women who became nurses between 1950 and 1975, two of them have mentioned that for them, it was a fantasy of 'middle-classness' that attracted them to nursing. I want to argue that the same fantasy, coupled with a fascination for medical knowledge, can compel the reading of medical romances. In her analysis of the 'fifties audience for medical programmes on television such as **Your Life in Their Hands** (BBC 1958-61) Karpf points out that female viewers by and large formed the majority of that audience. Most of the programmes at this time belong to a category Karpf has labelled as 'the medical approach', which sees the history of medicine as 'a soaring graph of progress, with successive scientific discoveries and breakthroughs extending human knowledge and curative powers, and replacing primitive nostrums and folk remedies' (Karpf 1988: 111). The 'medical approach' to sickness and disease was at its peak in Britain in the late 1950s, still unchallenged by the consumerist lobby that was to grow throughout the 'sixties along with other powerful liberation movements. Nor was it challenged by a 'look after yourself' approach, which began to percolate into government health policy in the early 1950s as the result of a growing recognition of the cost of providing free at point of delivery health care services. In the 'fifties, the medical establishment was at the peak of a pinnacle of popular belief in its power to cure and heal, with a result that doctors became 'folk heros' in popular stories, replacing sons of the gentry and other minor aristocrats as symbols of masculine power and virility.

The very concept of romance as a way of arranging reproduction between women and men is peculiarly western. In **The Alienated Reader**, Bridget Fowler points out that the material conditions for romance as a structure of feeling are first of all agrarian

capitalism, and secondly, the patriarchal mode of domestic production (Fowler 1991: 19). The pre-conditions for romantic literature as a genre are a fusion of the classic realist narrative form of the nineteenth-century novel with that of an older form, the fairy or folk tale. Modleski locates the sentimental novel as a precursor to Harlequin romances, a lineage that she traces back through the novels of Charlotte Bronte and Jane Austen:

‘In the classic (sentimental novel) formula, the heroine, who is often of lower social status than the hero, holds out against his attacks on her "virtue" until he sees no other recourse than to marry her. Of course, by this time he wants to marry her, having become smitten with her sheer "goodness"' (Modleski 1984: 17).

In her exploration of the romance genre in 1930s magazines, Fowler points out the frequency of the madonna/whore dyad, where the madonna has a ‘consuming commitment to duty’, self sacrifice (usually defined as love), and ‘displays her work ethic within the family, as an extension of this duty to the other’ (Fowler 1991: 57). By this time, domestic labour had replaced the charitable work of the Victorian middle-class heroine in favour of ‘the industrious wife’ and personal service to the husband. In these 1930s stories, ‘the paramount moral virtue in woman is her exemplary practice of pre-marital and extramarital chastity’ (ibid). The heroes of these stories are mainly businessmen and their sons, with doctors running a close second. According to Fowler, ‘essentially the doctor is the chivalric knight (of the Proppian fairy tale), like him he must pass various tests and demolish various obstacles before being rewarded with romantic marriage. Stories show the commitment to professional rules reigning supreme over other emotions (such as cash

interests or emotional entanglements). Whereas however the chivalric knight has a disinterested duty to kill, the doctor must disinterestedly save (Fowler 1984: 123). Elements of the ethical interests of the nineteenth-century domestic novel with its roots in the Protestant work ethic tend to be foregrounded in these stories, where the only 'villain' to be overcome is death itself.

The doctor nurse romance is a very particular variation of the romance genre's format. Given that on the whole, romance is a critically despised genre, the attention paid to it has tended to concentrate on broader patterns and themes rather than on studies of specific forms at particular times; (Fowler's work is one of the few exceptions). What is clear is that medical romances of one sort or another were popular in the 1930s, but it was only in the late 1950s that nurses became integral to the formula and that the formula became widespread and popular, not only in Britain but also in North America. The question is why did the medical romance become so popular during this period? The answer is complex, and involves looking at a matrix of factors which I have attempted to summarise under two main headings, aspiration and fascination. Before dealing with these two factors in isolation however, I want to situate them within the broader framework of 1950s culture and femininity.

If we step back and try to take a broader look at the position of women in 1950s and 1960s Britain, what becomes quickly apparent is the dearth of in depth socio-historical and cultural work available on women's lives during this period. Perhaps the most comprehensive account to date is Elizabeth Wilson's **Only Halfway to Paradise**, (1980) which mainly concentrates on the position of married women and

their relationship with the newly emergent welfare state. This book propounds what seems to be a general view of the period: that most female commentators and activists of the time considered the cause of 'reasonable' feminism to have been won. Women had gained the right to vote, to education, and had access of some sort to most careers. During the 1950s, they won in theory the right to equal pay in the civil service and in teaching. As Wilson points out however, behind the painted smiles of the ideal housewife, one of our most enduring images of 'fifties domestic harmony, there was a darker picture. Throughout the period, the number of women in the workforce actually increased from 21 per cent in 1951 to 32 per cent by 1961 (Westergaard and Resler 1975, quoted in Wilson 1980: 41). Whilst on the one hand women were inveigled by popular magazines to believe that their place was in the home, they were taunted by advertisers to believe that domestic drudgery could be alleviated by the latest labour saving devices. The catch twenty-two for many women was that they could only afford the new domestic appliances if they went out to work.

The 1950s was a period of economic boom in Britain and work was plentiful. Whilst women were vociferously told in publications and texts of all kinds that their place was in the home as wives and mothers, they were also being persuaded that they needed to go out to work for the good of the family. In one of the few books on the subject written at the time, **Women's Two Roles: Home and Work**, Viola Klein and Alva Myrdal tried to assess the impact of these conflicting demands of home and work on women's lives, but found little evidence of any systematic research into the problem (Wilson 1980: 53-55). The shortage of women in the labour force however



continued the recruitment crisis in traditionally low paid areas of women's work like nursing. This was in part resolved through importing labour from what were still at that time 'colonial territories' under British rule such as Africa and the Caribbean (see Chapter 2).

Ideas about femininity were contradictory throughout this period. On the one hand, there appeared to be more opportunities for women than ever before. On the other, as the case studies in Chapter 3 show, women who opted for a career in a traditional profession like nursing often did so because of the lack of other opportunities available, particularly for women from lower middle and working-class backgrounds. It was still extremely difficult for a woman to get into medical school unless daddy was a doctor, and even then she had to have better qualifications than her male peers. Educated women still tended to enter the other great female profession, teaching, where nationalisation of the education system had created a demand for teachers that was somewhat analogous to that in nursing. The only other obvious options for women with a modicum of education were secretarial work and banking, a situation that was to continue virtually unchanged until well into the 1970s. Whatever work a woman choose to do however, it was expected that she would give it up, if not when she married, then when the children were born. For many men with middle-class aspirations working in clerical jobs in the emerging retail and service sectors - such as my father and several of interviewees' fathers - having a non-working wife was a symbol of their upwardly mobile success and their ability to provide the family with the new products of affluence. In this scenario, the woman's role was to manage the household and tend the home - this was an era when traditionally

‘feminine’ crafts such as needlework, knitting and cookery dominated much of popular advice literature written by and for women.

The increasing popularity of all romantic literature throughout this period can be seen in part as a reflection of women’s increasing literacy. The 1944 Education Act had ensured that all children had the statutory right of education, initially to the age of 14, then 15 and later to 16. The debate about what kind of education girls should have was frustrated by a lack of statistical data, but by the early 1960s it was apparent that the overall proportion of girls to boys staying on at school had not increased. The assumption was that girls would marry, and their education would be wasted, and this was particularly the case when it came to attitudes towards working-class girls. The Crowther Report (1959) clearly stated that ‘the prospect of courtship and marriage should rightly influence the education of the adolescent girl’ (Baker 1989: 11), and the Newsom Report which followed in 1963 reiterated this point of view, claiming that girls should be learning feminine skills. In spite of this gloomy picture of the prospects for women gaining places in higher education however, all women were being educated to the age of fifteen, and more women were passing the eleven plus examination for secondary education at a grammar (academic) school than boys (Baker 1989: 12). It therefore seems probable that the overall literacy level of the female population was rising throughout this period.

That was certainly the view of the publishers responsible for the mass production of gothic romances in early 1960s America. Reaching middle-class women and retaining them as a reading public who would regularly consume their product was one of

reasons that this particular genre became so successful (Radway 1984: 32). There were however other influences on people's lives that signalled a major change for many women in terms of their collective experience. Much has been made in histories of the cinema at this time of the move away from urban centres to the suburbs, and the coming of television. In the post war period, inner city housing stock in Britain was in a deplorable state as a result of neglect by landlords and bombing during the war. New building commenced on the peripheries of major conurbations as part of the new state welfare policies, resulting in a rash of 'new towns' such as Kirkby on the outskirts of Liverpool which was built to house the inhabitants of one of the poorer inner city areas. People were removed from the communities in which their families had lived for several generations, breaking up the pattern of life and placing them, often in isolation, on the new estates. People were also encouraged to own their homes and mortgages were made easier for the ordinary working man, although not women, to obtain; house building boomed as more and more people moved to the new estates in the suburbs. New leisure activities developed as a result - gardening, 'do it yourself', and television watching. For the women involved - mainly the wives of upper working-class (blue collar) and lower middle-class men reaping the benefits of the 'fifties economic boom and apparent affluence - the benefits of all this were mixed. The new modern houses and domestic appliances certainly lightened the domestic workload, but isolation from female relatives and friends increased the burden of childcare and reduced opportunities for 'letting off steam'.

Reading books and magazines and watching television were popular leisure pursuits

for women isolated at home, a situation book publishers keenly exploited. In a press release written in 1988 to celebrate eighty years in publishing, Mills and Boon explain how they saw the relationship between the new consumer culture, reading romances and watching television:

In the 1950s the editorial style of Mills and Boon swung away from the harsh realities of the previous decade, and took on a fairy-tale quality; stories were exotic, taking readers away from Britain and the memory of war with international travel, foreign names and places. Colourful detail became still more important, and covers featured holiday resorts, dance halls and pretty dresses. Towards the late 1950s, however, lending libraries began to decline, and with them, Mills and Boon's major outlet. Readers could not afford hardback books, romance paperbacks were not yet available, and the taste for romantic fiction itself had not waned. It was the arrival of television, originally feared to be the downfall of reading, that provided the solution. The Doctor/Nurse theme, already successful for Mills and Boon, became suddenly more popular via television medical dramas. In response to this vogue, a small paperback publishing firm in Canada, Harlequin, approached Mills and Boon for the North American rights to some of the Doctor/Nurse titles, to then be produced under the Harlequin imprint. So successful was this enterprise that in 1960, Mills and Boon was able to turn its attention to the launching of its own paperback series (Mills and Boon 1988).

According to the publishers, it was the popularity of medical melodramas and medical romances that fuelled the transition in Britain from hardback to paperback novels, and

Mills and Boon's expansion into the North American market. Surprisingly, this connection has not been explored by students of popular culture or of romantic fiction. My analysis is therefore offered as a starting point from which such work could develop. The position I am taking here is not a particularly feminist one, and can easily be seen to have much in common with Gramscian notions of the way bourgeois culture works to incorporate those who are excluded from the material benefits of bourgeois culture into that very culture. It is not a position that situates female readers as unknowing sponges who absorb cultural meanings without thought.

What I want to argue is that the rise in popularity of this particular form of the romance articulates a change in feminine values which was to have particular resonance in public attitudes towards nurses and nursing. In the mid to late 1950s, when these books first became popular on a mass scale, certain conditions were beginning to prevail which would create new horizons of expectation for many women in Britain. Some idea of the different articulations with femininity and feminine values of women who came to maturity in the aftermath of world war two are conveyed in Thumim's study of women and popular cinema in Britain and Press's study of generational difference amongst American television viewers. Like Press, I have several convictions about the role of popular fictions in our society that are often thought to be contradictory in much of the literature on mass media reception (Press 1991: 173). The first of these is that popular fictional narratives (and in particular those distributed via mainstream films, paperback print culture, and televised serial and series dramas) disseminate and reinforce dominant ideologies of the feminine in liberal white western capitalist societies. The second of these,

following Smith (1988), Press (1991) and others, is that women have an active relationship with femininity which is manifest in the choices of narrative entertainment that they select. Both of these convictions colour the following analysis.

Whilst it has become unpopular to speculate about the activity of reading in favour of empirical and ethnographic work, I nonetheless intend to contemplate the appeal of doctor/nurse romances, given the dearth of empirical material available on the subject. First of all, a word about the sample. I have collected some forty plus Mills and Boon romances published between 1957 and 1989, clearly a very small number in relation to the overall numbers produced (some four a month since the early 'sixties). From these, I have concentrated on those that figure hospital nurses at the centre of the narrative, with an emphasis on books about nurse training. Amongst the earliest books I have managed to obtain, a significant number concentrate on the experiences of initiates. Interestingly, three authors dominate these earlier books, all of whom have a detailed knowledge of hospital life and medical and nursing procedures. There is a clear demarcation between authors who use the hospital as a background for a romantic drama, and those who include the hospital setting as part of the drama. For example, **Staff Nurse** (Valerie Nelson 1957) is a romance written in the style of the sentimental novel, with issues of class, social etiquette, breeding and money heavily foregrounded in the plot. In contrast, **Junior Pro** (Kate Norway 1959) is far more concerned with the contemporary conflict between marriage and career and the relationship between work and femininity. Whereas **Staff Nurse** promotes a religious, vocational picture of nursing with self sacrifice, self abasement

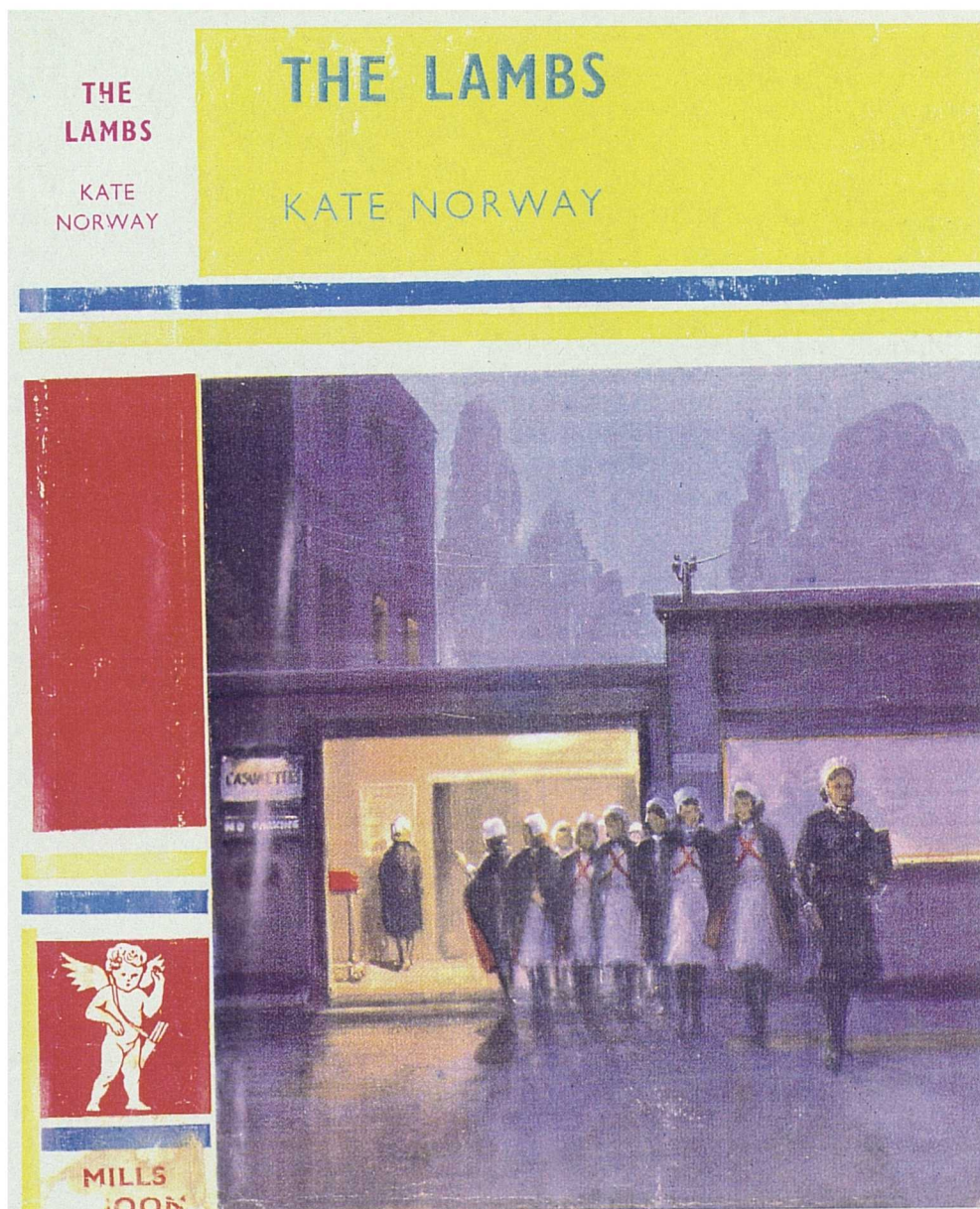
and self abnegation as the ideals encapsulated by the heroine, it nonetheless constantly states a preference for marriage, claiming that 'helping and encouraging a man in his career is the finest work a woman can do' (Nelson 1957: 127). In this view of nursing, the job is a stepping stone towards a well-bred marriage, and career nurses are viewed as deviant women. In many of the books, what comes across is not so much a problem with women working as nurses, but a view of career nurses (women in authority) as hard and masculine. These women are always single, never partnered with anyone, appearing alone and friendless. Any hint of lesbianism in nursing is completely absent from these texts. In **Junior Pro**, nurses remain single not so much out of dedication to their work but because the work leaves them no energy for being social (Norway 1959: 107). Although this narrative follows all the conventions of the stock romantic plot (older man, younger woman, two suitors and a scene where the heroine removes her clothes out of contingency thus 'innocently' arousing the passions of her admirer), the heroine insists on completing her training and obtaining her qualifications before she marries. The narrative resolution to this commitment to work is posed in terms of a 1950s notion of middle-class marriage which promotes separate but equal spheres of responsibility. The nurse and her doctor husband will be 'one person doing one job' (Norway 1959: 157).

Amongst nursing heroines of this period, a surprisingly high number come from the country, from farms, villages and small country towns. The hospital tends to be situated in the city, a juxtaposition of setting which has particular resonance in literature. The country tends to be metonymic for values associated with goodness, honesty, order, 'the natural', the city with corruption, insincerity and disorder and

‘the cultural’. Within the city however, the hospital operates as a large country house, a repository of the diminishing aristocratic values of the country. Hierarchy and order are maintained through traditional class and gender divisions. Threats to this order come in the form of ‘outsiders’. For instance, in **The Lambs** (Kate Norway 1965), a young woman is accepted for nurse training who is on probation. A debate ensues about what kind of girl is suitable to be a nurse. Most of the nursing heroines are however recognisably middle-class and white, with few exceptions. Where Black nurses are featured, they are also middle-class, their parents’ occupations specifically stated. Black nurses in these stories are always ‘one of our kind’, on their own and dependent on white cultural values. In **Night Duty at Dukes**, the Black nurse Theo discusses her marriage prospects with a friend, concluding, ‘I don’t want to go home and marry one of my own people. I’ve come to like Englishmen better. That’s an awful thing to say, isn’t it?’ (Andrews 1960: 29).

Southern Englishness (as opposed to Britishness) is given a primary value in these stories - Welshness and Northerness are given deviant, superstitious values that obstruct the rationality of modern medicine. Foreignness is seen as threatening and disturbing, unknowable and therefore untrustworthy. Given that these traditional ideological values underlie a great many of the stories, it is perhaps surprising to find that the one thing that they unequivocally share is support for the National Health Service. In numerous stories, private patients’ privileges are seen as unfair and unjustified, ‘Just because they’ve got money, why on earth should they expect to be treated as though their lives were more valuable than anyone else’s?’ (**The Lambs**





*Plate 5a The Lambs dust jacket, 1960s.*

1965: 79). Dedication to medicine for the sake of suffering humanity is given positive value, practising medicine as a way of making medicine or conferring social status viewed negatively. Nurses in these stories always marry doctors who support the positive values, so that in giving up their public role to support their doctor husbands, they are continuing to support the ideals and beliefs that have informed them as nurses. Their power as women becomes the power of social influence, and it is perhaps here that the attraction lies for the reader. To have money, social status and influence without compromising personal ideas or beliefs was certainly my mother's fantasy as an upwardly mobile post war wife and mother, a fantasy that Caroline Steedman claims has not been recognised or become visible because it stands outside the academic discourses that theorise working-class women's experience (Steedman 1986).

Aspiration cannot be wholly separated from the other strong attraction exerted by these texts, a fascination with medical knowledge and power. In some texts, this knowledge and power is encapsulated in the figure of the brilliant surgeon whose new surgical procedures will save people from death. In these books, the doctor tends to remain a distant, unknown figure whose 'truth' is discovered by the heroine once she decides to trust him. In other texts however, the doctors are much more human characters. The mysteries of medicine are revealed to them and the nursing heroines, through the narrative, involve the reader in solving medical mysteries and health problems. In initiate stories in particular, readers learn with new nursing recruits the language of medicine, including terminologies for describing the body and its functions and the shorthand or slang of hospital communication. The reader learns

something of medical discourse, as well as the power relations that are built into that discourse. These books surely offered to many readers the pleasure of 'insider' knowledge of hospital life, without having to be involved in the hard and dirty work of nursing - a point made strongly on the first page of **Junior Pro**, where nursing is described as hard work, 'not a thing you learn from books' (Norway 1959: 1).

In conclusion, the doctor/nurse romances of the late 1950s and early 60s can be seen as amalgamating fantasies of 'middle-classness' with illusions of medical knowledge and power into a single generic form, satisfying a demand for stories in which female characters gained access to social status, power and knowledge through their sexuality and femininity. Whilst the books support an ethos of white, middle-class masculinity, that ethos is nonetheless shown to be flawed. In fact, men who represent both curing and caring for the common good are shown to be relatively rare, with the negative attributes of doctoring for money and status depicted as 'villainous' more common. This ethical and moral standpoint clearly reworks paternalistic bourgeois liberal humanist values into a welfare statist framework, but leaves traditional class distinctions relatively intact. By giving the hospital the ethos of a large, country house, gender roles also remain intact. The frequent references to Florence Nightingale and the descriptions of nursing work tend towards a notion of 'housewifeliness'. Nonetheless, the texts are critical of certain masculinist assumptions about women's work as nurses, often stressing how nurses, as mediators between the patient and the doctor, play a crucial role in both the saving of lives and the promotion of patient well-being. In many of the texts, the picture is one of nurses as a competent and capable group of women who quite often do the thinking for men,

but never take the credit for it. Their sexual desires, often described as actively seeking satisfaction through pleasure in kissing and touching, become sublimated through 'good' doctors into a quasi religious ecstasy centred on the male because he will do good in the world. The welling emotions and tears aroused by the texts are cathartic, in the sense of releasing the pent up feelings and emotions that unfulfilled expectations and promises in every day life have generated, but also, as one nurse who reads these stories said to me, speak to a medical utopianism that she at least still felt she needed to cling onto.

## Part 5

### Soap and satire: the late 1960s and early 1970s.

The 1960s in British society are now seen by some as a time of turbulence and unrest, a period when traditional class distinctions were overturned and there was a new sexual freedom. A more pessimistic view however would regard many of the apparent changes as superficial, leaving the deeper structures of British society relatively unchallenged and unchanged. How were nurses seen and represented against this background of apparently changing sexual mores and class values?

Throughout the 1950s, the growing impact of television and television's portrayal of medicine and nursing were significant contributions to the discursive field of public attitudes towards the two professions. In particular, two programmes in the late 1950s scored high on television audience rating scales: **Your Life in Their Hands** (BBC 1958-61), a documentary series celebrating surgical intervention, high technology curative medicine and pharmaceutical therapeutics; and the long running **Emergency Ward 10** (ITV 1957-67), described at the time as a 'documentary drama' of hospital life, focusing on life-threatening conditions and heroic medical intervention. Between them, these two programmes changed the face of medical broadcasting in 1950s Britain from a preventative orientation to a curative one...and erased 'all recollection of the fitness and fibre obsession from producer's minds' (Karpf 1988a: 12). No longer were medical broadcasters extolling listeners to take care of themselves and eat plenty of fibrous foods; instead, viewers were to be

informed and educated (and undoubtedly entertained) by the spectacle of modern surgical methods and procedures, with their accompanying narratives of successful intervention and cure.

Karpf sees this change in broadcasting practice, from the 'look after yourself approach' to the medical perspective, as part of a more generalised scientific enthusiasm pervading 1950s society. To paraphrase her, the 1950s bubbled with therapeutic optimism, it was the era of Sputnik, of the development of space technology, which seemed to exemplify the Macmillan government's 'you've never had it so good' conservative credo. Chemicals and pharmaceutical manufacturing led the field in the creation of new industrial complexes (and empires). The new age of affluence had an unbounded belief in the potential and efficacy of science and technology. Along with economic expansion came notions of consumer choice. Instead of being addressed as an aggregated mass, the public were increasingly addressed as consumers and individuals. By early 1961, a pamphlet accompanying the **Your Life in Their Hands** series talked of the importance of medical research and the value of medical scientific methods, reflecting a growing belief in research as a panacea and doctors as a 'superior race of human beings whose calling raises them from the ordinary level of human fellowship' (Karpf 1988a: 52/53). This phase of programming marked the beginning of what Karpf refers to as an infatuation with the London teaching hospitals - an infatuation that is also clearly apparent in films like **The Feminine Touch** (1956) and much of the popular doctor/nurse romantic literature of the time.

Karpf stresses that by the beginning of the second series of **Your Life in Their Hands**, television's imperatives for drama and excitement had begun to play a major role in the shaping of these documentary programmes. New technology using videotape recording (available for the first time in 1956) was enabling coverage of the operating table to be far more intimate. The television audience had grown markedly throughout the 1950s, a growth reflected in the purchase of TV licences, from 343,000 in 1950 to 10 million by 1960 (Docherty, Morrison and Tracey 1987: 23). Independent television had effectively challenged the BBC's monopoly, to the extent that the BBC had a new constituency, its audience, whose needs had to be taken care of. Whilst the BBC were intent on conveying the liveness and excitement of real life medical dramas, however, the producer of ATV's **Emergency Ward 10** (ITV 1957 - 67) had a slightly different agenda; 'We wanted to overcome the pre-war attitude of the British public to hospitals as institutions, places to be avoided at all costs. We wanted people to respond to new research in medicine' (quoted in Karpf 1988a: 183). Like many of its counterparts in medical romantic fiction, **Emergency Ward 10** was characterised by plots that dealt with life and death crisis and rare infectious diseases; it used a great deal of medical jargon and portrayed doctors as 'boisterous young philanderers with an unquestionable sense of vocation' (Ibid).

Only two of the later episodes of this long running series are available for viewing in the National Film Archive; much of the series was transmitted live and never recorded on videotape. From this rather limited source, it is however possible to get a sense of the programme. Perhaps most striking to a modern viewer is its static visual field; as viewers, we only get the smallest suggestion of a ward (and a world)

beyond the bedside, where most of the action takes place. The drama is script led, with the cameras following the doctors who do most of the talking and motivate the action. When nurses speak in the doctors' presence, which is usually to question or clarify a suggested course of treatment, the camera rarely cuts to them. Nurses are present as background characters who take orders, and occasionally explain medical dialogue to patients, thereby acting within the fiction as translators of medical terminology for the viewer. Class relations between doctors, nurses and patients are explicitly referred to in the script; working-class patients refer to the doctors in several places as 'stuck up'. Amongst the nurses, there is some slight variation in accent, but little to differentiate them otherwise. Nurses obey doctors' orders without question on the wards, although there is one scene in which a nurse queries a doctor's diagnosis of her own medical condition. Nonetheless, the overall picture is one of male medical control. The doctors are all white, male and middle-class, and it is they who are seen to control the fictional diegesis through their use of medical discourse. The patients in these particular episodes are working-class in most cases, except for one woman, an Asian immigrant, who is the focus of medical concern. She remains virtually speechless throughout, the object of the doctors' medical gaze mediated by the camera's view of her. In the doctors' dialogue, her 'otherness' is seen as the cause of their mis-diagnosis; 'The colour of her skin foxed us at first. Like clots, we thought the pigmentation inside her mouth was normal for her'. Within the fictional diegesis her helpless character is a function of a realist aesthetic that attempts to incorporate social issues into the body of the text - a text that presents the healthy white, male middle-class body as the 'norm' against which others are compared. In this world view, disease and ill health are the property and problems of 'others' -



women, the working class, and non-whites.

Throughout its ten year run, **Emergency Ward 10** received considerable praise for its attention to accuracy of medical detail, but became increasingly criticised by the broadsheet press for its emphasis on the personal lives of the medical staff. Nonetheless, the press reviews also reveal that it did make some attempt to deal with contemporary issues in the health service, portraying in 1962 an unauthorised meeting of nurses to discuss a pay claim (May 1962), a nurse getting sacked (December 1963), and a love affair between a white house surgeon and his Black female colleague (July 64), parts of which were banned by the ITA because they were considered 'too suggestive'. **The Daily Telegraph** (17/7/64) loudly proclaimed that the cuts 'had nothing to do with colour prejudice at all'! By 1965, the success of the drama in dealing with medically related social issues and promoting health education campaigns was acknowledged by the Ministry of Health, although quite how they reached this conclusion is unclear. The series faded out in 1967 largely unremarked, no doubt in part as a result of the increasing presence of American medical dramas on the small screen, with their own particular blend of high production values and handsome young male doctors, accompanied by short skirted nurses in sexy uniforms. As Kalisch and Kalisch (1982a) have pointed out in their exhaustive study of American television's imaging of nursing, throughout this period of American programme production the nurse is a silent handmaiden who does little that could be identified as nursing work. Even her role of patient advocate and mediator is taken over by sympathetic, caring medical men.

Given the preference shown by the audience in the mid and late 1960s for the compassionate, caring American medic, whether he was Dr. Kildare, Ben Casey or Marcus Welby, it is perhaps worth contemplating why nurses disappear into romantic fictions and doctors dominate small screen melodramas. Karpf sees these dramas as reaching beyond the conventions of drama and human interest stories, endorsing the expression of feelings such as vulnerability and fear more commonly articulated by women. The doctor in these stories is often a wise man who mediates family relationships and restores harmony. In a decade marked by the opening up of difference between men and women, black and white, left and right, 'the doctor programmes reasserted hope and social stability', healing the damage and offering reassurance that the system could succour and patriarchy provide (Karpf, 1988: 191).

Karpf's speculations about the reasons these shows were successful in Britain may well be on the right lines, but it is worth noting at this point some of the reasons why they were so successful on American TV. In an in-depth analysis of the relationship between television and medical power, Joseph Turow (1989) points out that the formula for medical melodramas has remained largely unchanged since Dr. Kildare was first serialised on the cinema screen in the 1930s. In 1961, an enterprising producer tried to break with the formulaic pattern of the Kildare/Casey format by developing a series that was based entirely on nurses. **The Nurses** ran for three series over three years, but from the early days it was predicted that the female leads would eventually cause the show's downfall because there were no male leads to attract male viewers during prime time viewing. Whilst this argument may seem a bit surprising - after all, the audience for medical melodrama has in Britain at least been conceived

as a largely a female one, when it is placed in the context of American network programming policy at this time, it makes more sense. Reaching the greatest number of people was the principle objective of American advertisers and sponsors, which meant that there was little by way of differentiation in terms of approach to the audience, who were conceptualised as an aggregated mass. This meant that programme making was not targeted to appeal to specific groups of people, but operated on the principle of common denominator factors. The audience for every show had to be maximised, and high ratings were the only criteria for success. Since male viewers tended to control prime time evening viewing, shows increasingly mixed high macho and high melodrama in an effort to appeal to both sexes. Advertisers were less interested in shows that dealt with social and ethical issues, more interested in entertaining people. This led to a number of policy changes in the screening of medical melodramas which were to be nails in the coffin for **The Nurses**. First, doctor series had to be screened in the late evening, secondly the shows had to revolve around male physicians, and thirdly the dramas had to enact clear, high-emotion issues of life and death, not the politics of the hospital or the medical system. This change in programming policy, instituted throughout American network television, ended what Kalisch and Kalisch consider to be one of the most positive representations of nurses ever to appear on the small screen (Kalisch and Kalisch, 1982a). It is worth noting, though, that the show did not please American nurses at the time, most of whom vented their criticism via their professional associations and the nursing journals (Turow 1992: Chapter 6).

**The Nurses** was never shown in Britain. Throughout the 1960s, American medical

melodrama imports such as **Dr. Kildare** entertained the British television audience with high tech life and death dramas, where nurses featured as background setting or occasionally as efficient personal assistants for the doctor heroes. Any sense of personal autonomy or professionalism was clearly absent. These shows attracted large audiences during prime-time, no doubt reflecting their attraction for the male as well as the female viewer since it seems likely, based on later research evidence, that male household members controlled later evening viewing (see Morley 1980 and 1986). The combination of machismo and melo in these shows clearly re-works 1950s ideas about nursing as a professional service to the community into a 1960s ethos of self-abnegating servility to medicine and medical men which rendered fictional nurses virtually silent and only visible as decoration and sexual spectacle.

If nurses were invisible as active agents on the small screen, on the large screen they continued to be objects of fun and derision. The **Carry On** series and the **Doctor** films kept on lampooning them throughout the 1960s. In British films, nurses continued to be figures of fun, albeit with less clothes on than in the previous decade. In American films, they became creatures of sex. Following the general drift in American films of this period towards misogynistic images of women, nurses become devious criminals (**The Burning Court** [US 1963], **Nurse-Made** [US 1970]), murderers (**The Honeymoon Killers**, US 1970), prostitutes (**Woman of Desire**, US 1968) and nymphomaniacs (**I, A Woman**, Den. 1966). They get murdered (**Night of Bloody Horror** [US 1969], **The Strangler** [US 1964]) raped (**Day-Dream**, Jap 1964) and generally abused (**Temptation** US 1962). Most of these pictures date from 1962, the point at which the Hays Code, for so long the regulator of Hollywood's

moral conduct, was defeated by an action in the Supreme Court, ending a system of censorship which had remained virtually unchanged since 1934 (Randall 1977: 432-457 and Maltby 1990).

The image of nurses as creatures of sex has not been dealt with in any depth in any of the existent literature on the nursing image. Nurses have been seen as creatures of sex since Victorian times, but this image has been heavily policed by social mores with more or less help from the censor depending on the overall social climate. The professional view seems to be that it is better ignored, rather than discussed and aired. This silence still meets those who try to open up debate on the subject, as I discovered in my initial attempts to research it (see Chapter 4).

One film, more than any other, seems to sum up fictional representations of nursing and hospitals on the small and large screen by the early 1970s. Released hot on the heels of *Carry on Matron* (GB 1972), *The National Health or Nurse Norton's Affair* (GB 1973) mixes tragedy and farce into a black comedy that satirises Britain's ailing National Health Service and the nurses trying to work in it, situating the action in contemporary Britain and its troubled economic climate. The film opens with a shot of a pillared portico hospital entrance and the sound of a PA exhorting the hospital staff to use less hot water because the boiler is failing. The country house style architecture of the hospital building may call to mind nostalgic memories of a great and noble past, but the sound track works to contradict any notions of an idealised or romantic view of the present. Cutting to an internal shot, we are shown a Black nurse in traditional uniform escorting a white patient down a corridor where

a Black woman wearing a sari is on her knees scrubbing the floor. Entering the ward, a general air of anarchy prevails; a patient tears around in a wheelchair, the male patients cat call abuse at the nurses, who try to keep smiling cheerfully through the chaos. In the kitchen, the porters sit smoking and drinking tea. The PA continues to call in vain for Dr. Singh. In the patient's sitting room an American medical melodrama, 'Nurse Norton's Affair', is just beginning on the television. Made to resemble a 1970s style **Dr. Kildare**, the opening shots emphasise the modern hospital, its wide corridors, comfortable patient rooms, and high-tech medical support systems. The contrast with the ailing British NHS hospital is immediate and obvious. As the frozen images of the actors of the TV drama appear on the screen, it becomes apparent that the tired, frazzled British nurses and doctors we have just seen are also the glossy stars of the American style melodrama. The film cuts between these two fictional 'realist' styles, juxtaposing the ironically grim realism of British social issue drama with the high production values and melodramatic style of American prime-time television.

Perhaps within this juxtaposition of contrasting fictional realities, it is possible to see more clearly how the institutional constraints of different production practices shape fictional realisms into specific representational forms. The black and white low budget soap format of **Emergency Ward 10** was superseded in the mid 1960s by American series melodramas with their glossy formats and high production values, a move that coincides with the introduction of colour TV viewing in Britain and the use of more aggressive advertising techniques by independent television companies. Additionally, the mood and tone of the American product, with its emphasis on

individual cure situations and the doctor as a medical god, clearly suited the British medical discourse of 'cure', with its emphasis on research as the panacea that would solve the problems of ill-health and disease. This discourse was prevalent in medical broadcasting, as Karpf has pointed out, because it met broadcast television's remit of educating and informing at a time when the BBC began to actively compete with ITV for viewers, adding spectacle as an ingredient to television programmers' recipes for successful series in both fictional and documentary formats. Within the broadcasting environment, nursing's professional discourse of 'service' was taken at its word; nurses as a group did little to challenge that picture. By the late 1960s however, it was clear that the service ethos of nursing was being increasingly challenged from within the profession; for the first time, nurses began to vociferously complain about their outmoded working conditions, outdated pay scales and obsolete working practices. In the longer term, their activist stance dramatically changed television's fictionalised stereotype into a much more complex and dynamic model.

As I discuss in more detail in Chapter 2, the late 1960s and early 1970s were something of a watershed in nursing history, both in terms of the relationship between nursing and the NHS, and in terms of the battle for control within the profession between the Royal College of Nursing and the main nursing unions- principally COHSE and NUPE. In this battle for control for the hearts and minds of nurses, the media became a determining factor, establishing nurses' anger at their pay and conditions of work on the pages of every major daily newspaper and many television news bulletins in a manner that has only been equalled since by the late 1980s news stories of babies dying for the want of nurses trained in intensive care procedures.

The 'raise the roof' campaign was the first active involvement of the Royal College of Nursing with the media in a sustained campaign to pressurise the government to increase nurses' wages under a 'no-strike' banner. This was followed throughout the early 1970s by a series of union led strike actions and workings to rule, which finally culminated in the nurses' pay settlement of 1974. What these pay disputes revealed were the underlying problems of financial crisis graphically ironised in **The National Health Service or Nurse Norton's Affair** - problems that were to be brought into the living rooms of television viewers through the social realist format of the series **Angels** in a medical melodrama with a difference. The difference was a focus on nurses and their work, encompassing both the detail of day to day nursing practice and to some extent the broader framework of operation within the dictates of NHS management policy and limited resources. This programme told 'the nurses story' for a change, leaving the medics on the periphery of the action.

**Angels**, first broadcast on BBC 1 in 1975, was something of a milestone in British medical series drama because it was the first series to focus on nurses and their working lives, rather than on doctors and their ethical problems and romantic encounters. Based on an idea by script editor Paula Milne, one of the first wave of female graduates from the National Film and Television school, it was written by female writers and produced by Julia Smith, latterly more well-known for **Eastenders** and the more recent failure of the BBC's early 1990s Euro soap **El Dorado**. **Angels** quickly established itself as a popular favourite among young and old female viewers because of its strong female characters and positive portrayal of feminine values (Gallagher [1982] quoted in Karpf 1988a: 212). So what was it about the series that



was seen as different? How did it portray hospital life for working women?

In an article in **The Listener** (September 1975), Paula Milne claimed that the different approach to hospital drama taken by **Angels** is based on its series (rather than serial) format, with a team of writers independently responsible for each character rather than being expected to develop story lines set against a hospital backdrop. In the early 1970s, serial drama was conventionally developed by teams of writers who would generate story line material against a background set. This could equally be the hospital setting of, for example, **General Hospital** or the motel setting of **Crossroads**. Decisions on the detail of the storylines would be made at script conferences, in a similar mode of production to that of American serial drama. By changing the production format of **Angels** to a series, Milne changed the narrative style, the way that information and pleasure are delivered to the audience. This gave the programme a new 'authenticity', with the result that it was critically viewed in a similar fashion to how **Z Cars** was seen in its day as showing a more realistic view of police life. It also led to the programme getting the nick name of 'Z Beds', since like its predecessor, it was expected to pull in the early evening audience, entertaining them with its realist informational mode of address.

**Angels** focused on the working lives of six student nurses at various stages in their training - an approach somewhat analogous to the 'take four girls' approach of the national recruitment drive for nurses that was current at the time (see chapter 2, part 5). Rather than developing individual storylines, each writer was given a character to develop, and set off to research the specific circumstances that her character would

be likely to encounter. This varied, from the experiences of young initiates coming into nursing straight from school, to the more experienced third year nurses who had served their time on the wards. Only the first two of these early episodes of **Angels** are available for viewing, so my following commentary necessarily has a rather narrow perspective. Nonetheless, it is clear that **Angels** did not shirk from refracting the nursing image through a critical prism, especially in its depiction of internecine disputes concerning authority between the generations. It also tried to take on board the thorny issues of pay and conditions.

The opening sequences of **Angels** enact the 'putting on' of a nursing identity in a similar fashion to the recruitment literature of the period, showing the transformation from 'ordinary girl' into nurse through donning the distinctive uniform. This transformation sequence then cuts to the hospital badge, and the nursing image engraved upon it, a direct reference to nursing's vocational roots in religious orders through the nun/nurse in her habit and veil. The fictional hospital, St. Angelas in London, is a re-presentation of a London teaching hospital with its ancient traditions in charitable care, not a converted Victorian workhouse or an early municipal hospital. The choice is significant, for it means that what we shall see on the screen is a very specific view of nursing identity at this time, one that to a large extent ignores the staffing shortages, racial tensions and class issues raised by union activists working in the less glamorous and poorer funded general and psychiatric hospital sectors. By focusing on a high profile London teaching hospital, **Angels** reinforces a particular professional ideal of nursing at a time when the Royal College of Nursing's bid for hegemony as was in fact under severe stress due to its 'no strike'

stance on industrial action. Whilst this broader political framework was engaged with in the programme at the level of individual complaints and debates about pay and conditions, the broader issues concerning the divided identity of nursing were never addressed.

By concentrating on the experiences of six student nurses at different stages in their training, **Angels** dramatised the experience of becoming a nurse, showing how each individual negotiated the stresses and strains of the training process. These dramatisations tended to emphasise the physically demanding side of nursing work, not avoiding the 'dirty' aspects of patient care, the irritating petty restrictions of hospital life and routine, and the feelings of despondency and depression that most nurses have to deal with at some point or another during their training. The series also dealt with conflict between nurses of different ages and rank as the young initiates took on board increasing responsibilities and developed the skills and expertise necessary for final qualification. The initiates, whilst representing particular feminine identities and differences, do develop characterisations which take them beyond the simplistic stereotypes of nurses in, for example, **The Feminine Touch** (1956), but the programme's commitment to documentary realism now seems slowly staged and lacks in-depth analysis of the issues it was foregrounding. Although the programme did deal with contemporary issues, by introducing a male student nurse for instance, it did not investigate the deeper, structural changes in nursing that were occurring as a result of the instigation of the Salmon management scheme and the re-organisation of the health service in 1974. Both of these events had a far reaching effect, in that they introduced a male management model into a traditionally female

occupation; Salmon is referred to by many in the profession as 'the male nurses' charter'. By not addressing these institutional factors, the realism of **Angels** can be seen as compromised, continuing to promote a feminine ideology of nursing at the very time that the ideology was starting to be eroded.

**Angels** then can be seen as presenting a middle-class drama of liberal individualism and ethical dilemmas in which national political policy making tends to be reduced to localised conflict between individuals. This is also true of the programme's depiction of racism, which perpetuates a notion of racism as an individual problem rather than an institutional one. Compared to a later programme like **Casualty** (BBC 1 1985-date), which has managed to foreground issues of politics, race and sexuality at different times, **Angels** now seems tame entertainment and a poor example of an issue based drama. It did however alter the agenda for programme makers by placing nurses at the centre of medical drama, and its high audience ratings (up to 12 million viewers) were a measure of its popularity and success.

### **Some tentative conclusions**

During the twenty five years covered by this study, public perceptions of nurses changed markedly, a process in part mediated by the increasing presence on television of dramas and documentaries about medicine and hospital life. At the beginning of the 1950s, a strong service ethos pervaded notions of nursing identity and representation, an ethos which meant that female nurses were held in high regard because they were seen to sacrifice notions of self hood in order to serve others - primarily patients, but also the nursing profession itself. Nursing was regarded as hard and dirty work and a sense of vocation was thought to be needed in order to be able to do it. Throughout the 1950s and into the 1960s this notion of vocational service changes in the public imagination. No longer is nursing serving the community, (with an underlying implication of serving the nation and notions of Britishness) but instead a different notion of service begins to prevail. Increasingly, nurses serve the new medical ideologies of cure rather than the traditional nursing ideologies of care.

Nowhere is this more apparent than in their servile relationships to the physical embodiment of these ideals, mythical god-like medical men. The newly developing international image markets in television programmes made spectacular American images of these men increasingly available to British audiences. Nurses became background presences in small screen melodramas, whilst on the big screen they were satirised as petty authoritarians and sexually frustrated spinsters, or depicted as

creatures of sex. Only in the despised 'women's genre' of romantic fiction could an image be found that gave nurses minds, bodies and voices of their own. Written by women for women, these stories told not only of passionate love between nurses and doctors, but negotiated a range of personal and moral issues around the meaning of nursing that only began to appear in televisual form after the nurses' pay campaigns began to actively challenge media representations of nursing as silent, self-sacrificing femininity. In these books, a fascination with medical men is part of a fascination with medical knowledge; to know one is to get to know the other, to see behind the mask of curative medicine to the driving (male) force behind it. The journey from innocence to experience that so many of these books portray is one that maps out the possibility of a career and marriage through partnership with a medical man. Caring is restored on an equal footing with curing because the man is dependent on the woman's capacity to provide it, and it is his acknowledgement of his need for her caring capacities that ultimately makes the nurse powerful.

By the late 1960s and early 1970s, nurses were actively altering the public perception of their role through their vociferous campaigns for improved pay and better working conditions. The success of their claims raised their public profile, and sparked a new interest in the fictional representation of nursing, at least on television. *Angels* can certainly be seen as growing out of this new level of public consciousness surrounding nurses and their role. Submerged since the early 1950s into fantasies of male medical power and female subordination, the eruption of the nurse into a speaking and visible subject coincided with the beginnings of what is now regarded as second wave feminism. Generally excluded from feminist accounts of the period because of its

sybiotic relationship with femininity and the female caring role, nursing's stand against the state can none the less be seen as part of the general discontent with women's roles that swept through British society during this period. The effects on the image of nursing can in retrospect be seen as significant; although *Angels* now looks dated because of its slow pace and visual style, for the first time a serious drama series was commissioned which totally centred on nurses. This was no small achievement for a female profession which throughout the post-war period had either been lampooned and satirised, or more commonly, completely ignored.

From the mid 1970s on, nurses were increasingly aware of their image in the media, forming monitoring groups and pressure groups in order to try and maintain a sympathetic public consciousness of their role. Over the years, this action has only been successful in part, as recent writings on nursing and the media point out (Salvage 1987, Bridges 1990). Perhaps one reason for this is that nursing, whilst trying to present a united face to the public through its professional discourses of care, is in fact a deeply divided profession and has found it difficult to negotiate its differences in the rapidly changing health care environment of the past forty-five years. In the next chapter, these divisions will be examined in some detail through an examination of the discourse on recruitment and attrition, focusing on recruitment images and their relationship to policy and procedures.

## **CHAPTER 2**

### **Introduction**

In this second chapter, I want to examine the relationship between fictional images of nurses and images used to recruit school leavers and young people into the profession. I aim to show that fictional images and recruitment images share a symbiotic relationship even though they appear to inhabit ostensibly different discourses. This difference is often assumed rather than analysed because of the different spaces that the images inhabit: fictional images circulate in spaces associated with leisure and consumption, whether that space is a supermarket bookstall or a long running television series; recruitment images circulate in spaces related to work, such as school careers files, employment advice centres and occasionally magazine, cinematic and television advertising space. Recruitment images are created both in opposition to and in accord with fictional representations, the degree of similarity between the two forms varying in specific historical moments. It is this dynamic relationship, between the nursing profession's presentation of an idealised identity and fictional re-presentations of that ideal identity, that this chapter aims to explore.

The chapter is organised in five sections: part one traces the history of nursing as a divided profession, an essential key to understanding the post war representation of nursing; part two analyses 1950s images of recruitment in relation to these internal divisions and conflicts in nursing; part three discusses the increasing influence and



visibility of male nurses and their relationship to the middle-class feminine ideal of professional nursing; in contrast, part four points to the invisibility of Black nurses in relation to their growing contribution to nursing provision. Finally, the Briggs report provides a framework in which to analyse the industrial action of the late 1960s and early 1970s, and argue that this militant action was largely responsible for fracturing nursing's white middle-class 'angel' image of supplicancy which had dominated both the professional and the public imaginations for so long.

Although the substance of this study is the period from the passing of the Nurses Act in 1949 (which, for the first time, admitted male nurses to the General Nursing Register) to the Briggs report in 1972 (which, for the first time, placed the nursing image high on the policy agenda), in order to understand the different images of nursing and nurses presented to the public during this period, it is necessary to examine the historical contexts that informed these ideals. The divisions within the profession itself and the divisions created by institutional contexts, primarily the organisation of the hospital system, are an essential key to understanding the modern nursing image. The tripartite system of hospital organisation which existed before the formation of the National Health Service was reflected in similar tripartite divisions within the profession; an explication of these divisions forms the body of the first part of this chapter.

In the second part of the chapter, having understood the institutional base from which the divisions in nursing emerge, it is possible to understand how the two different conceptions of nursing work circulating in the 1950s recruitment literature were

motivated by conflicting ideologies of nursing. One of these was a Fordist conception of nursing as a semi-skilled job that demanded a minimum of basic education and training in order to be able to carry out a series of clearly delineated tasks and activities under the supervision of a senior. The other was of nursing as a profession, with its own codes of practice, fields of expertise and responsibilities. These two very distinct ideologies, although rooted in Nightingale's two conceptions of nursing as both a calling and a military campaign against the diseases of poverty, found fertile soil in different institutional contexts which gave rise to different attitudes to issues of class, status and professional power.

The late 1960s are something of a watershed; even before the Briggs report in 1972 recommended major changes in recruitment policy, for the first time men were being recruited for all branches of the nursing profession in mass advertising campaigns. This was partly due to an acute shortage of trained staff which had continued to dog the profession since the end of the war without resolution. More significantly perhaps, it can also be seen as a direct result of the growing numbers of men in high positions in nursing wielding their professional power. Part three examines how gender becomes a visible issue for the first time across the field of nursing work, with men no longer targeted by recruitment literature specifically for the traditionally male specialities of psychiatric and prison work.

The fourth section of the chapter looks at recruitment drives beyond the local and national context examining how nurses were recruited from Britain's former colonies, with particular emphasis on what was then known as the West Indies and Malaya.

Many thousands of women and some men arrived in Britain in the 1950s to train as nurses. Their expectations and their experiences form the substance of this section.

Finally, recruitment literature in the early 1970s is examined in the wake of the recommendations of the Briggs report, placing changes in representation within a broader framework of public attitudes and perceptions. The increasingly militant stance by some sectors of the nursing profession finally persuaded the Royal College of Nursing to support claims for better pay and conditions. Arguably, these campaigns had considerable impact on public attitudes as well as professional organisations; they certainly played a role in fracturing the idealised unitary identity of professional nursing into an increasingly complex network of groups and alliances.

## **Part 1**

### **A history of a divided identity.**

The professional image of the nurse has undergone considerable changes in the past forty years, changes which arguably began with the introduction of the National Health Service in 1946 and the admission of men to the general nursing register in 1949. The image of the nurse used by the profession for recruiting trainees today is no longer necessarily female, and is as likely to reflect the medico-scientific aspects of the job, as well as the 'caring for people' aspect. Images these days also tend to represent the variety of jobs open to a nurse after qualification, rather than only the field of general nursing and a variety of people now appear in recruitment images, rather than a particularly idealised vision of white femininity. Nursing's recent past is a period when traditional images began to be questioned, and traditional ideas lost ground. As the demand for nurses outstripped the availability of young white British women for state registered (now general) training, the influx of initially men, and then men and women from the former British 'colonies' began to challenge the profession's idealised image of itself.

#### **The roots of difference**

General nursing's domination of the field of nursing work was clearly established by the time this study begins. It is the image of the general nurse, with her Nightingale connotations of selfless devotion to duty, that tends to have reigned supreme in the public imagination during the first thirty years of the NHS, although, as Chapter 1

has shown, this image was not without its ambiguity. This image of the 'ministering angel' continued to be represented across a range of recruitment materials in the period 1950-75, and was itself a site of struggle both within nursing culture and between nursing leaders and the government. The image reflected a pull in two diametrically opposed directions; on the one hand, it was used to equate ideas of selfless devotion to serving the new national health service, whilst on the other it was used by a section of the nursing hierarchy to maintain their ideas of professional status. Note that in both cases, the sick individual in need of nursing care has no part in the nexus of representation - hence my emphasis on the image encapsulating an ideal of nursing as femininity, rather than representing aspects of nursing as work, the latter only emerging in the later period of this study.

The struggle to control the image of nursing is in part due to its particular associations with female authority and power. This authority and power has its material roots in the institutional structures of the hospital system prior to the foundation of the NHS, which gave rise to the divisions amongst women working as nurses. In particular, the image of selfless devotion was associated with nurses in the voluntary hospitals. The determination of their leaders to dominate the other areas of nursing in the interests of professional identity and status has recently been explored by Maggs (1983). The image of the Nightingale nurse became the most popular image of nurses and nursing in the latter half of the nineteenth century, representing the emerging control of general nursing by voluntary sector nurses and their quest for professionalism. In this section of the chapter, I want to look at how this image of idealised asexual white femininity was established in the years prior to

the second world war and the role that debates about the need for greater nursing manpower (sic) played in the struggles to control the profession.

By the end of the nineteenth century, Nightingale's work had popularised nursing as an occupation for well-bred young ladies, many of whom were able to take up key appointments in the major voluntary hospitals after a brief period of training. As this group became increasingly powerful, they were able to impose a stiff three year training on new recruits and tried to prevent anyone who had not undergone this training from practicing as a nurse. In spite of Nightingale's opposition to a registration scheme that would, in effect, only recognise those who had undergone the three year training as able to bear the title 'nurse', the 'professionals' were able to persuade the government that an Act of Registration was essential to safeguard both the public and the medical profession from unqualified practitioners. The bill was finally passed in 1919. The educational standards adopted for entry to training schemes were however too inflexible to produce enough nurses for all the kinds of nursing work that were needed. The poor in particular were rarely able to afford qualified nursing skills, and the prestigious voluntary hospitals balked at the increased salary load they would have to meet if they only employed registered nurses.

In his **History of the Nursing Profession**, Abel-Smith points out that nursing was virtually the only exclusively female profession at a time when the first wave of feminine emancipation began to rock the establishment. Mrs Bedford Fenwick, one of the most active campaigners for nursing registration and a tireless worker for the establishment of nursing as a profession was a well-known suffragette and an admirer

of Mrs Pankhurst. For Bedford Fenwick, the nurse question was **the** woman question...the nurse must be recognised as 'an individual of some importance in the state' (Abel-Smith 1975: 65). In her eyes, this could only be achieved by excluding the servant class of women, those who had traditionally undertaken nursing duties, from entry to the profession. Admittance had to be confined to the daughters of the higher social classes if nursing was to be recognised as a profession separate from and free from the control of the medical establishment. Educational and financial barriers would ensure that only the better class of girl could become a nurse and 'undesirable' recruits, (those from the lower social classes) would be kept out. At this time, nursing was still regarded by many in society as a disreputable occupation. One of the arguments used by Mrs Fenwick to drum up support for her campaign was that the richer classes needed to be protected from the criminal element in nursing - only through a registration scheme would they be assured of having nurses of 'good character' to look after them in their own homes. Registration was seen therefore not only as a means of conferring status on those who had it, but also a means of controlling entry to the profession.

Not all nurses supported Mrs Fenwick and her organisation, the Royal British Nursing Association, in their bid for registration. Nightingale herself was doubtful about the efficacy of the scheme, and considered it more important that nurses were of 'good character' rather than from a particular social class. By the end of the nineteenth century however, her influence was starting to wane. More forceful opposition to the Association's plans came from small provincial voluntary hospitals, where it was feared that the new training regulations would make their own training

schemes ineligible; they would therefore lose a valuable labour source, as well as much of their local prestige. Many of the matrons of these institutions were worried that the formation of a nursing council to oversee nurse training and registration would rob them of their own local power bases. Others were against the exclusion of servants and lower-class girls from the nursing ranks, claiming that many of these young women made the best nurses because they were accustomed to servicing the needs of others.

These debates raged within the British nursing establishment between the years of 1889 when Mrs Fenwick established the British Nursing Association and 1919, when the battle for registration was finally won. The feuds that raged during these thirty years left their marks on the profession, and inflected its development throughout the 1930s. Amongst all the debates, the training and recruitment of staff - how to provide enough trained nurses to staff the hospitals - has always been an issue. Traditionally, nurse training was heavily concentrated in hospitals. To understand the issues raised by particular images of nurses used in recruitment debates, some examination of the legacy of hospital organisation that the NHS inherited and, debatably, did little to change, is necessary.

### **The hospital system prior to 1948.**

Before 1948, there was a three tier system of hospital administration consisting of the voluntary agencies, the local authority public health committees and the Poor Law or public assistance committees (White 1985a: 1). The first group had their roots in pre-Victorian and Victorian philanthropy, and were funded by upper-class benefactors



and charitable donation; the second group derived from the Public Health movement, and were charged with prevention of the spread of disease. Many of these were known locally as 'fever' hospitals. In the third group were institutions that cared for the chronic sick, aged and infirm, and the asylums, both of which had their roots in the old workhouse infirmaries. The status of these hospitals, and of their patients, and of the nurses who cared for them was intricately connected with their origins, as were the working conditions and salary arrangements between the three tiers.

The voluntary hospitals operated as autonomous organisations, independent from government policy and control, although they were increasingly reliant on government funds to remain solvent. In these hospitals, the matron was recognised as head of all nursing services including the training school; she was autonomous, reporting directly to the governors. In both the other types of hospital, funding came largely from the local rates, which made them more susceptible to political intervention. The matrons of these hospitals were responsible to a medical superintendent, overall head of the municipal hospital, who reported to a local health committee or medical officer of health. The nurses working in these hospitals tended to be non-resident and were sometimes married, unlike in the voluntary hospitals where residency tended to be enforced and marriage often entailed resignation (White 1985a: 2).

Since the introduction of the Nurses Registration Act in 1919, a mandatory syllabus of training and common examinations had been established for all nurses. A general register of nurses was set up, with a supplementary register for male nurses, mental and mental deficiency nurses, sick children's nurses and an open part for any other

speciality, e.g fever nurses. The General Nursing Council controlled only basic nursing training until 1943, when a further Nurses Act empowered the registration of nurse tutors. By 1948, in spite of the efforts of the General Nursing Council and the Royal College of Nursing to adopt a policy where all nurses shared the same basic training, there was still a very wide range of basic trainings available for specific spheres of work. Specialities such as ophthalmic and tuberculosis nursing continued to maintain their own training programmes, and the traditional split between the three types of hospital care and their differing status had not been healed.

### **Setting the scene for the 1950s: professional divisions in the 1930s.**

During the 1930s, the divisions in the profession were reflected by the wide variety of trade union and professional associations which tried to organise nurses and campaign on their behalf. The second world war, like the first, again brought a degree of homogeneity to the profession, but discontents over pay, conditions of service, working conditions and educational standards for trainees continued to fester. Amongst activist organisations in the 1930s, Dingwall identifies three main groupings: the hospital managements' position which had strong representation from the voluntary sector; the College of Nursing; and the trade unions, which tended to be heavily concentrated in local authority run hospitals (Dingwall *et al.* 1988).

### **The hospital managements.**

Dingwall sees The Lancet Commission, launched in December 1930 to investigate nursing shortages, as representative of the hospital managements' group viewpoint. The Commission consisted of representatives from primarily the voluntary sector, and

included only two hospital matrons. The aim of the Commission was to offer 'recommendations for making the (nursing) service more attractive to women suitable for this necessary work'. Heavily biased towards the special circumstances of the voluntary sector, the report alleged that nursing was losing out to business, social work and teaching as a 'suitable' form of employment for well-educated, and therefore at this time almost inevitably, middle-class and upper-class young women. Dingwall's evidence however makes it clear that it is unlikely that such women ever became nurses in anything like substantial numbers, and he points to a lack of statistical evidence for the claims made by the Lancet commission. By 1939, the Athlone Committee was able to demonstrate that recruits were mainly culled from clerks, typists and shop assistants - the lower middle and 'respectable' working classes (Dingwall *et al* 1988: 99). This evidence is not dissimilar to the pattern of recruitment in late Victorian England researched and analysed by Christopher Maggs in his **Origins of General Nursing** (Maggs 1983).

The Lancet report did, however, serve to point out the degree to which petty rules and regulations, particularly in nurses' homes, tended to make the profession unattractive to young women living away from home. By the 1930s, the attitudes of many parents were a good deal more relaxed than those of their Victorian forbearers. Nonetheless, authoritarian practices both on the wards and in nurses' homes continued to dominate many trainee nurses' lives. These attitudes were to survive well into the early 'seventies, in spite of recommendations in numerous government reports that they should be annulled or amended. (For example, the National Board for Prices and Incomes investigation in 1968, the Briggs report in 1972).

## **The College of Nursing**

The College of Nursing saw itself as the representative voice of the leaders of the profession, and had worked hard to achieve this status. Founded in 1916 on the strength of the registration movement (although Mrs Bedford Fenwick was not a wholehearted supporter), the College was formally constituted along the lines of the Royal College of Physicians and Surgeons in the hopes of achieving comparable professional respectability for nursing. Its initial aims were to promote education and training, to introduce a uniform curriculum, to recognise approved training schools and to lobby parliament in respect of nursing and health policies. Trade unionism of any sort or form was specifically banned from its articles of association (Abel-Smith, 1975: 89). Male nurses and mental nurses were excluded from membership, in much the same way that they were later to be excluded from the general nursing register. The College undoubtedly became a focus for the registration movement as its membership grew, and was finally in competition with the views of the Royal British Nurses Association lead by Mrs Fenwick. The failure of these two groups to agree on the presentation of a joint Registration Bill in 1919 eventually led to the then Minister of Health deciding to present a government bill. The passing of this bill gave the College of Nursing dominant membership of the General Nursing Council. It was at this point in time that the College became indisputably the representative voice of the profession, a position it was to consolidate throughout the 'thirties against a growing challenge from the trade union movement. The College was strongly allied to The Association of Hospital Matrons, another group formed in 1919 on the back of the registration movement.

One of the ways that the College group tried to recruit young women into the nursing profession in the 'thirties was through writing for popular middle-class weekly magazines like **The Zodiac**. Agnes Pavey was a well-known writer on nursing affairs and a nursing historian who certainly had sympathy with the aims and objectives of the College of Nursing. She is one of the historians that Abel-Smith is rather critical of in his treatment of nursing history. Ms Pavey's history covers the development of nursing from an art, to a vocation and then to a profession, and tends to concentrate on 'great' people as the movers of history, rather than government policy or economic determinants (Pavey 1938). In an undated article for **The Zodiac** found in the Royal College of Nursing archives, Pavey stresses the advantages of nursing as a profession in relation to other professions which have recently opened their doors to women:

'Few (professions) offer such peculiar advantages to suitable candidates as Nursing does, for no scholastic qualifications other than an ordinary sound education are essential for entry into a training school and no fees are demanded for professional education'.

Asking why nursing is an unpopular profession today, she claims that it suffers from an 'over-emphasis on the vocational aspect that followed the work of Florence Nightingale'. In her brief history of the profession's unpopularity, she points out how 'lurid press coverage' had persistently failed to differentiate between students and staff in matters of salary, perhaps a direct reference to media reportage of the 1937 campaign for increased remuneration led by the unions.

Pavey goes on to give a description of training, living conditions, salaries and

superannuation, ending her article with a brief history of the College of Nursing. Pavey, from this brief description, is clearly a 'professionaliser', one of the group of nurses identified by Abel-Smith (1975) and Dingwall *et al.* (1988) with a particular set of values which tended to be nurtured by the prestigious voluntary hospitals. In line with these middle-class professional values, the photographs chosen to illustrate her article share a similarly 'high cultural' framework of reference. Centred on the opening page is a photograph of a nurse writing or sketching on a notepad, a skeleton hanging in front of her. The traditional relationship between artist and sitter is here reversed; instead of the woman being the passive recipient of the (male) artist's objectification of her, here the woman is in the objectifying position. Instead of the (male) doctor studying human remains for the pursuit of knowledge, the nurse occupies that position. On the second page of the article, the two photographs are composed and lit similarly to an eighteenth century Dutch still life painting. Similarly, 'assisting the Surgeon' is composed and lit in a style that resembles Rembrandt's anatomy lesson.

I am not claiming that these photographic images have any kind of intentionality behind them, other than to illustrate the writer's textual descriptions with visual aids. Whether these photographs have been composed with their fine art counterparts deliberately foregrounded is also unlikely, although 'quality' photography at this time tended to be based on similar notions of classical composition to fine art. I merely want to point out that this style works in a particularly apt way when coupled with Pavey's article. Professionalism is coupled with classical references, thus maintaining an ideological status quo rather than challenging existing ideas and beliefs. Nursing,



*Plate 6: Illustration from Pavey's **Zodiac** article*

in Pavey's terms, is a 'separate but equal' sphere, where although the woman can become the objectifier, she can only do so to enable her to assist the surgeon, as the final image makes clear. The image on the first page of self-motivated, analytical study is followed on page two by an image of subservience. The preparation of special diets under the supervision of a woman clearly in a management role (wearing the cap and bow associated with Nightingale schools of nursing) is a 'professionalisation' of the traditional female role as a preparer of food, as is the picture below of the tending of infants.

The pictures and the text work together to continue to exploit the divisions of labour in health care under the label of 'professionalism'. Unlike the NALGO campaign document which combines an image of supplicancy with demands for better living conditions and wages for trainee nurses, this article dismisses such campaigns and their reportage in the press as in some way distasteful, maintaining a class-based difference and distance from those who seek to nurse for anything other than professional status. There are then clear historical reasons why the College of Nursing supported **The Lancet's** view of recruitment since it tended to count amongst its members the career orientated professionals from the voluntary sector, rather than the nursing rank and file. This group lobbied to keep nursing a restricted profession, in spite of a chronic shortage of trained staff.

### **The Trade Unions**

The labour movement saw in the unregulated municipal hospital sector an opportunity to expand and develop its membership base. Many of the general and white collar



unions set out to recruit nurses during the 1930s. The National Association of Local Government Officers (NALGO) was one of the unions that saw in the Lancet Commission's report an opportunity to recruit members by formulating 'a comprehensive recruitment and training scheme for women engaged in the Public Health Services.' Their 'Women Public Health Workers' Charter' (1935) was addressed to nurses and was particularly concerned with nurse training and career development. The one portal system of entry to the profession favoured by the College of Nursing and its supporters was seen as a clear deterrent to young women from the respectable unionised working-class who wanted to become nurses. Many of these young women were denied a career in nursing because of the gap in educational provision between the standard school leaving age and the commencement of nurse training at 18. The report claimed that 'the young woman of today ...is physically and mentally several years ahead of the pre-war girl' and that 'the system must be made to conform to modern requirements if for no other reason than that comparatively few parents can afford to continue their girls' education up to 18 years of age' (A Woman's Calling, NALGO Women's Charter, 1935).

Although its primary address is to women working as nurses, the image used by the union on the front of its 'Women's Charter' brochure is interesting because it does not use the nursing uniform or any visual signifiers that might immediately call to mind the Nightingale ideal. The image depicts a knee length drawing of a woman wearing ordinary everyday clothes; a small sketch of a classical building with a large 'red' cross (the emergency medical service symbol) overprinted onto it occupies the lower right hand corner of the picture. The woman is looking out over the reader's

right shoulder, her arms outstretched and palms turned outwards, a pose suggesting supplicancy, service, vocation. Coupled with the large capital lettering across the top of the page, *A Woman's Calling*, and the dominance of the cross over the building, the overall impression given by the cover is of a religious manifesto rather than a campaigning political document. As Katherine Williams points out however, the word 'calling' has a history in nursing that dates back to Nightingale's definition of nursing: 'they call it a profession, but I say that it is a calling' (Williams 1978). Since 'calling' involves total submission and eradication of the self, the use of this term, combined with the picture of supplicancy and the cross, must have been a deliberately thought out attempt to convince the vocationalist element of the nursing workforce that they deserved a better deal, as well as an attempt to raise their political consciousness. In the foreword, the choice of imagery is somewhat justified by the text: the scheme 'should give hope to the girl whose education and disposition fit her for the hospital and health services'. The NALGO manifesto uses a traditional image of a woman 'offering herself up' to win support amongst female hospital staff for its campaign for better entrance prospects, salaries and working conditions for nurses. In attempting to achieve this aim, a traditional image of women's servitude and vocation is juxtaposed with modern (feminist) demands for better pay and working conditions within the body of the text.

The brochure is interesting because it replays the split in nursing that had become apparent even in Nightingale's day - a split that led her to voice her disapproval of her rivals, and in particular of Ethel Bedford Fenwick and her feminist sympathies. Whereas Fenwick's efforts had been geared towards making nursing an exclusive

profession for middle and upper-class women in support of the contemporary feminist agenda for equal access to the professions, NALGO's campaign was using the same terms of reference to achieve opposite ends, greater access to nursing's professional ranks for young women from relatively 'lowly' backgrounds. The class bearings of early feminism are revealed in this encounter, a legacy which modern feminism, similarly to modern nursing, has not always acknowledged.

NALGO's proposals became recognisable government recruitment policies in the post-war world. They included optional pre-nursing curricula for girls in secondary schools, provision within the technical school curriculum to provide pre-nursing training from the age of 15/16, evening continuation classes and a scheme for a two year training for practical nurses leading to the qualification of State Enrollment. Other recommendations included national minimum salary scales and grades, and a national standard of service conditions. In addition, weekend and summer schools, scholarships and prizes were to be offered as incentives for encouraging career development and professionalism. Due to their dominance in the local authority health sector, NALGO claims that there were more nursing staff in NALGO at this time than were members of any other single nursing organisation.

NALGO was not however affiliated to the TUC; there was a fragmentation of campaigning effort until the formation in 1937 of a co-ordinating committee, the National Advisory Committee for the Nursing Profession. This issued a Nurses Charter, which combined with well-organised demonstrations, caught the attention of the national media (Pavey's 'lurid publicity'). Extensive coverage was given to

nurses pay and working conditions. This growth of industrial militancy and the public support it attracted led to the Ministry of Health setting up the first comprehensive enquiry into the nursing profession, the Athlone Committee. Nursing history scholars (Abel-Smith, Dingwall *et al.*, White) are in general agreement that this committee's interim report 'has a clarity of analysis shared by few other official documents on nursing' (Dingwall *et al.* 1988: 103). Its recommendations closely reflected those of the TUC charter. The cost of implementing the proposals was however an anathema to the financially straightened voluntary sector who would have to match the higher standards being proposed by the municipal hospitals.

War was again the engine which drove the government into intervening in nursing affairs by enacting the standardised payments scheme recommended in the Nurses Charter. The government was driven to pass legislation which would enable staff to be able to move quickly from one location to another as need determined, unhindered by pay differentials. Again, the rival factions within the nursing profession were unable to agree on either the pay scales or the implementation of a regularised scheme; the government imposed its solution in the form of the Rushcliffe Committee, which produced its first report in 1943. In spite of its opposition to government interference into nurses pay and conditions the (by now) Royal College of Nursing had a majority of seats on the staff side of the negotiations, and finally achieved their own aim of widening the pay differentials between unqualified and qualified nurses (Dingwall *et al.* 1988: 104). The Ministry of Labour took over responsibility for nursing recruitment, continuing to be responsible for national campaigns until 1957.

During the war years, there was general agreement within the coalition government that there should be some sort of comprehensive health service established that would cover all forms of curative and preventative treatment. The details of the development of the national health service are not the concern of this thesis, I only want to remind the reader of what I pointed out earlier, that the existing hospital system was left largely intact, and that because of this the attitudes and working practices of those within the institutions also remained intact. What sociologists refer to as the 'culture' of institutions was preserved, rather than altered. In nursing terms, this meant that there was no radical shake-up of ideas and beliefs amongst the various nursing factions, even though they were being faced with what was potentially the most challenging period in their history. Whilst White (1985a) points out that nursing organisations were entirely omitted from the consultative process that led up to the NHS Act in 1946, implying that they were 'left out', Dingwall claims that 'there is little evidence of pressure from nursing organisations for consultation on this, or indeed on any other aspect of early NHS legislation or policy (Dingwall *et al.* 1988: 107). Dingwall goes on to point out that there was 'considerable opposition (from the ministry) to appointing people in any sort of representative capacity'.

The NHS Act of 1946 established 14 regional hospital boards and 388 hospital management committees; each committee was responsible for a group of hospitals which were organised according to geographical factors and medical function. Medical teaching hospitals were allowed to retain their autonomy and report directly to the Minister of Health. Large voluntary hospitals tended to remain relatively independent within the hospital management committee groupings, or easily

dominated the group in terms of administration, organisation, policy making and planning (White 1985a: 3). Some of the old 'poor law' institutions became residential homes, thus obviating the need for trained nursing staff and demoting those who worked in them to the status of attendants, or social service officers.

Towards the end of the war, the National Advisory Council on Nurses and Midwives undertook to research and report on the training of nurses, commenting on the serious shortage of trainees and calling for substantial improvements in their treatment and training. Many of the Advisory Council's recommendations were adopted by the Wood report, a government Working Party set up in 1946 to examine the recruitment and training of nurses. At this time there were over 11,000 vacancies for trained staff, 2,200 more than qualified each year from all parts of the register (White 1985: 4). Whilst accepting that there was a need to increase recruitment from secondary schools, the working party also recommended that girls leaving elementary education should be accepted for training to make up the shortfall.

This seemed to set the pattern for the way the Ministry of Health was to regard the position of nurses in the new NHS. A ministry circular in 1948 entitled **Nursing and Domestic Staff in Hospitals: Notes for guidance of HMCs** treated nursing and domestic staff alike in respect of their workloads, with only a few hints as to what tasks should be undertaken by domestics rather than nurses. According to White, this report set the stage for the way nurses were to be treated by the ministry until the early 1960s. Internal divisions within nursing made it possible for the government to nationalise nursing and nursing recruitment without consulting nursing's

professional leaders. In the next section, the implications of government intervention and control are traced in relation to recruitment images used on brochures and leaflets in the 1950s.

## **Part 2**

### **Class divisions: job or profession?**

#### **Internal struggles for control in the post war period.**

In this part of the discussion, it has to be borne in mind that the health services were not fused to the state in the inseparable way that they appeared to be some twenty-five years later. What White (1986a) refers to as 'the ideology of the common good' had not at this point taken root in the profession. At the beginning of the national health service, although many senior nurses were in favour of its introduction, some were not. The same sort of splits and divides that had caused divisions in the profession since 'the thirty years war' over registration were still operative. The teaching hospitals and the large voluntary hospitals (often one and the same thing) still regarded themselves as the professional elite of the medical world, and tended to recruit all their candidates for nurse training from the independent and grammar school sector. Hence the minute amount of information in publications produced by the Nursing Recruitment service on assistant (pupil) nurse training.

These elite schools of nursing often had long waiting lists and tended to accept trainees on the basis of personal recommendation. Many of the trainees were the daughters of doctors and other middle-class professional people. As Jillian MacGuire points out in her review of recruitment research of the 1940s, 50s and 60s,

'recruits whose educational attainment levels are well above the prevailing minimum entry requirements tend to be over-represented in intakes to schools



of nursing attached to teaching hospitals, whilst those at the lowest levels of academic attainment are to be found in disproportionate numbers in schools attached to the non-teaching hospitals' (MacGuire 1969: 56).

Schools attached to the large municipal (regional hospital board) hospitals tended to draw their recruits from the immediate geographical locality, supplementing their intake with recruits from overseas, particularly in the psychiatric sector. Very little is known about the actual distribution of overseas students, a problem I shall return to later in the chapter.

The shortage of trained staff continued to cause both the nursing profession and the ministry of health concern throughout the 1950s. Matrons travelled abroad in search of recruits, and incentives were given in the form of travel grants and bursaries to young women and men to come to Britain to train as nurses. Many were tempted by the prospect of a qualification which would enable them to return to their own country and practice. Little by way of incentives seems to have been offered to British born men however, other than to train for the traditional male specialities. Men in general nursing were still few and far between, most of those practicing having qualified during the war. This situation changed during the 1960s as increasing numbers of men rose in seniority in the profession, as I discuss in part three below. In spite of these changes, the problems of attrition did not abate until high unemployment filled schools of nursing for the first time in 1975.

A number of research projects were initiated to study the questions of recruitment and attrition throughout this period, most of which took a functionalist approach to the

problem. These research projects, often undertaken by university sociology and/or psychology departments tended to emphasise certain individual personality characteristics in the 'failure' to adapt to nursing, analysing factors such as background, education and personal disposition; they did not on the whole focus on institutions or their training and employment practices. (See, for instance, Cross and Hall (1954) in MacGuire 1969: 168-169, Knight (1965) in *ibid* 177-178 and Liverpool Regional Hospital Board (1965) *ibid* 178-179.) The search was on to try and find an 'ideal type' of young woman, a person who could readily be targeted for recruitment and would complete the training satisfactorily. (See for example Houlison (1946) in MacGuire, 1969: 142-143, Lee (1959) *ibid*: 144-145, Petrie and Powell (1951) *ibid*: 156-158.)

Given the influence of the 'generalists' within the GNC, (see below) intellect was not seen as the most important quality in a nurse. The 'generalists' values were similar to those of Nightingale, seeing nursing as a job for those of sound character who had no difficulty serving others - training what would have been considered in Nightingale's day 'the servant class', upper working-class girls from respectable backgrounds. From the 'professionals' point of view, this tended to result in a lowering of standards which they sought to combat through their control of nursing in the former voluntary hospitals. These internecine debates created a narrowness of vision amongst the leaders of the profession, which the department of health seems to have reinforced in the research commissioned, undoubtedly because a constant stream of young women in training continued to be the cheapest way to staff the wards. Although the problem of attrition was a constant source of anxiety to the

profession, the government, as numerous reports showed, considered nursing a semi-skilled job. There was no real incentive for them to be seriously perturbed about staffing the hospitals with trained nurses since the nursing wage bill was the highest cost the NHS had to bear. This in some measure perhaps accounts for the total lack of attention paid by researchers in the above reports to actual working conditions, such as split shift duties, part-time working, attitudes to married staff and the provision of workplace nurseries so that staff with children might be encouraged to continue working or to return to work.

In the United States, research was however beginning to highlight different attitudes to work amongst nurses. Habenstein and Christ (1955) identified three main types of nurse with very different conceptual frameworks of what nursing was all about. The first, the professionaliser, was preoccupied with medico-scientific and nursing knowledge and tended to be more interested in curing diseases than caring for the patient in any sort of wider sense. The second, the traditionaliser, tends to match the stereotype of much popular fiction, supporting the attributed Nightingale vocational ideal of administering 'tender loving care' to her patients. Notions of selfless devotion to the care of the patient and a deferential 'handmaiden' attitude to medical practitioners tend to predominate in this group. The third type, the utiliser nurse 'is the prototype of the nurse as a piece rate worker, a low level non-professional organisational employee who simply does her job' (Matz (1969) in Mercer 1979: 136).

Within the British context, these ideas translate into three dominant ideologies;

nursing as a profession, nursing as a vocation, and nursing as a custodial activity (Williams: 1978). Williams focuses her analysis of the divisions in nursing culture on the relationship between tasks and status, describing how these changes affect the helpless sick adult. As in Nightingale's discourse, however, there is assumption that the helpless sick adult is male. Although Williams is arguably using a generic 'he' here, the continued absence of female patients from the discourse on patient/nurse relationships, both in professional literature and popular imagery is notable. Poovey (1989) notes a change in Nightingale's concept of the patient from the brutish, lower-class male beast of her earlier military rhetoric to the silent man who is too pre-occupied with his ill health to be troublesome. The relationship between patient and caretaker is transformed from one based in hierarchical divisions of class authority to one based on gender difference through the metaphor of the idealised middle-class family, where sexual difference can be controlled because the nurse is a literal or metaphorical mother (1989: 184-185). The patient's dignity is preserved by the knowledge that his child-like state of dependency is ministered to by somebody who considers it a privilege rather than a duty to attend on him. In the nineteenth century, basic nursing care (feeding, washing and attending to bodily functions) in the absence of antibiotics and antisepsis, could and sometimes did save the lives of those who would have otherwise died. As Williams points out, the training curriculum which was to establish certain bedside nursing tasks as essential for the well-being of the patient (bed baths, feeding and toileting) also transformed the status of the sick. No part of a sick person's body was ever unnecessarily exposed during these processes by a nurse of worth and sensitivity. Although the helpless sick adult 'may have lost *his* independence, *his* worth as a person is increased by the nurse's dedication to tasks

performed in willing service to helplessness' (Williams 1978: 40, my emphasis).

The image of vocation was central to Nightingale's conception of nursing, and became widely adopted as her ideas spread throughout the hospital system. Vocation implies servicing the needs of others, both doctors and patients, as a form of sacrifice of the self, an idea that masks the power hierarchy built into the doctor/nurse relationship, and the powerlessness of the patient. Professional ideology, on the other hand, demands that the nurse be highly skilled, rather than selfless and dedicated to her work. Notions of humanitarian service and eradication of the self stand in stark opposition to ideas of self-worth, status and personal autonomy. As Dingwall *et al.* (1988) have pointed out, the professional nurse is more concerned with curing than caring; this emphasis tends to objectify the patient and his (sic) illness into a mass of clinical terms and judgements. The adult condition of helplessness experienced by the patient is treated by the nurse as a clinical state. In modern professional nursing, how the patient feels tends to be less important than knowing the correct clinical labels, monitoring increasingly complex technology, and carrying out complex clinical procedures and observations. Formerly skilled tasks, such as the monitoring of bodily temperature by thermometer and basic bedside nursing care, tend to have been relegated to those who are less skilled, and therefore cheaper to employ. As Williams points out, 'an ideology of vocation becomes dysfunctional or obsolete where skilled tasks require judgement rather than obedience, and since the acquisition of skills has to be paid for, the tasks to which they relate cannot then be regarded by society, doctors or nurses as menial... seen as skilled they require an assertion of self in creative and innovative action' (Williams 1978: 41).

A professional concern and interest with the clinical side of curing, as opposed to the vocational emphasis on caring, tends to be biased in favour of nursing the 'crisis', and then rescinding care of the patient to those who are less skilled. If the person continues to remain in a state of helplessness (ie has been deemed incurable), he or she is likely to be transported to an institution where long term care will be provided by groups other than the 'professional' nurse. The helpless adult, whose consciousness of her/his condition will vary in relation to the degree of disability experienced, is likely to receive custodial care, which according to Williams, 'evaluates helplessness in adults as a regression to infant behaviours' (1978: 43). Although Williams does not draw the parallel, the ideology of this group may well have its roots in the disenfranchisement from nursing culture they experienced as successive waves of professional activity have sought to exclude handywomen, nursing auxiliaries and other carers from nursing's professional institutions (Ehrenrich and English 1973).

Williams' task orientated approach to the divisions in nursing is a very different one to that adopted by White, Dingwall or Abel-Smith, concentrating as it does on the helpless patient as the focal point of the definitions. William's tripartite analysis maps onto that made by Dingwall and others, suggesting that the ideologies of nursing in place by the mid 1970s were as dependent upon their institutional basis within the hospital system as they were a century before. In this context, White's analysis of the political regulators in British nursing gives an added dimension to the changes brought about by nationalisation (White 1985b).

White identifies three main interest groups in nursing: the managers, the specialists (or professionalists) and the generalists. The generalists are described as those workers who perform unskilled or semi-skilled tasks under the supervision of a specialist. In nursing, this tends to apply to those who maintain that nursing is a practical occupation, that academic and intellectual qualifications are not necessary, that there is no need of a theoretical base and that first level training to a registration standard is all that is needed by way of preparation. The term describes an occupational ideology where the members are class-conscious, accepting of a hierarchy, and used to working under supervision. This group are more likely to join trade unions for solidarity and negotiating power, and insist on experience as a criteria for promotion.

The specialists or professionals seek to maintain control over their work, working without the supervision of other nurses. They tend to have taken additional qualifications and try to achieve expert status within their chosen speciality. Whilst this tends to challenge the hierarchical structure of nursing, they favour the administration of nursing via nurse managers whom they also expect to be specialists within their chosen field. Specialists, as White points out, tend to respect and acknowledge specialists in other fields.

The nurse managers are the planners and policy-makers, and work within a multi-disciplinary bureaucratic framework where the culture of management pre-dominates. To be effective, they must have power, and power is bought through the application of management rather than nursing skills. This group has a history

of trying to control nursing by attention to manpower (sic) needs, suppressing the development of specialists and professional education in the interests of economy. White also claims that this group feels challenged by the authority of the professionals, and feels more at ease with the generalists, who are unlikely to challenge the hierarchical status quo. The power and authority at one time invested in the image of the voluntary hospital matron are here shown to be splitting into two separate nursing identities. One has the power to hire and fire nursing staff, but no authority in the specialist areas of nursing knowledge; the other is an 'authority' in her chosen area, but her power is confined to developing her own speciality and participating in nurse education.

These three groups, with their different strategies for seeking status and different definitions of what status actually entails, form the three main interest groups in nursing in post-war Britain. In 1950, 26 out of the 36 members of the General Nursing Council took their seats for the first time. Half of these were newly elected representatives, and half were newly appointed. White identifies a profound change in the composition of this group, which was not appreciated at the time. Senior nurses on the earlier GNC had trained before educational entry requirements were relaxed to meet war-time need, and tended to promote professionalisation of nursing through recruiting candidates from secondary schools and raising the standards of nurse training. In 1944/45 they had attempted to get the minimum entry qualification, relaxed to meet war time staffing needs, re-introduced. They wanted to set the entry standard at the pre-war School Certificate level. Many who sat on the 1950 GNC had however entered nursing through the open recruitment policy



introduced in 1938; in their eyes, the need for labour for the newly nationalised health service was of greater importance than raising educational standards.

It was not until 1959 that the Ministry of Health agreed to a resumption of educational entry requirements, by which time the values of the matrons had taken a subtle shift, from one of service to the patient to one of service to the NHS. This new ethic, based on what White calls 'the common good' became the basis for all future decision making. One of the effects of this change was to lower the entry standard for nursing from its pre-war requisite of five subjects passed in consolidated examination, to a two 'O' level minimum which could be taken serially. 'The GNC had changed from being an instrument of education to being an instrument of recruitment', and 'became the agent of the government and employing authorities' (White 1985: 26).

In her account, White is highly critical of the role played by the major representative bodies of nursing - the GNC, the staff side of the Whitley pay negotiating council, the Standing Nurses Advisory Committee and the council of the RCN. She claims that the matrons, selected by the Ministry of Health and the employing institutions, were chosen because they followed the line of acting in the 'common good'. She says 'I recall no occasion when the argument of 'for the good of the profession' prevailed' (White 1985: 30). Her analysis of the political struggles in nursing echoes the earlier struggle described by Abel-Smith (1975), Maggs (1983) and Dingwall *et al.* (1988), where general nursing claimed a professional identity for itself whilst ignoring or decrying the goals of other groups, such as asylum nurses. In this case

however, the label 'generalist' has come to mean something different. No longer are the generalists those eschewing professionalisation; they are seen, along with managers, as luddite-like in their endorsing of the common good, the by-product of which was a de-skilling of the nursing workforce and the employment of a generalist level of labour.

### **Recruitment images in the 1950s.**

Recruitment images from the 1950s on will now be analysed with White's account very much in mind. To what extent do the images try to attract those with few educational qualifications? What are the differences between recruitment images for state registration and state enrollment? What effect does the continuing shortage of nursing labour (a process that lasted virtually unabated until 1975, when for the first time there were more nurses qualifying than posts to be filled) have on the way young women were encouraged to regard nursing work?

The nurse represented in the Ministry of Labour's 1950 recruitment brochure is a far cry from her traditional Nightingale counterpart. She is young and attractive with fashionably arched brows and short wavy hair. Her address to the reader of the brochure is very direct; she looks straight out from the page with an open, smiling mouth, the darkness of which is suggestive of lipstick. Her eyes are similarly emphasised. Her hat sits neatly on top of her head, leaving much of her hair revealed. The white collar looks less rigidly starched than in previous representations and her apron is drawn with shadowing to indicate its soft folds. Her short sleeves also have the appearance of softness about them; the overall impression is one of soft

femininity rather than starched rigidity. This is emphasised by her posture, which has been drawn from the side to accentuate her feminine curves, catching her in motion, her face turned to glance outwards as she 'flies by' with her tray. On the tray, she is carrying a kidney shaped dish with a white soft looking substance in it, probably cotton wool. There is also a rather indistinct jar or container with a spoon or possibly a thermometer sticking out of it. Behind her, there is a clipboard pinned to the wall and some flowers sketched in - the one symbolising her observational and recording tasks, the other the nurses 'essential' femininity. The image bears a startling resemblance to that drawn on the front cover of the popular nursing books for girls, the **Cherry Ames** stories, discussed in Chapter 1.

Given the imagery that the Ministry of Labour could have called upon, the use of an image that could be equated with popular fictional representations in books for girls and comics is highly significant. Nightingale was not the only nursing hero to have emerged in the recent past. Figures like Edith Cavell, who died doing her duty in the First World War and Sister Kenny who founded the Australian nursing service have heroic status within our culture generally, and during the 1950s certainly had heroic status within the hierarchy of the profession as Miss H's comments in Chapter 1 confirm. Clearly, the government are presenting the managers' ideal image here, rather than that of the professionalisers.

A closer examination of the signifying systems of this brochure does however reveal some interesting dichotomies for the historian of image production. The back of the brochure is very similar in style to the front, although the nurses pictured here are



*Plate 7: Front cover, 'Your Chance', 1950s.*

sketched rather than drawn in detail, serving as a reminder of the image on the front at the point where the words invite the reader to arrange for an interview 'to discuss my future as a nurse'. The word nurse, printed in large capital letters, is the boldest and blackest of the images on the page, and matches the scripting style of the brochure's final statement. Next to a sketch of 'Cherry' buttoning up her cape are the words, 'The noblest of all social service for a woman'. Like the word 'nurse', social service is presented in capitals, one word below the other, reiterating a notion of service that is presented in the image on the cover. When teaching this brochure cover picture to mixed seminars and groups, there has always been an element of surprise that the image they are viewing is a 1950s representation of a nurse. Many people have read this image as an image of a waitress, and presume the figure is carrying a tray of food. The idea of 'waiting on' someone is clearly present to many readers of the image, although the rest of the brochure, produced as it is from a conglomeration of previous government materials for recruiting nurses, tends to refute the idea that this is what nursing is all about.

Page 2 of the brochure has a large heading, the hospital team. Underneath this are a series of circular photographs of the team members - surgeons, radiographers, domestic staff, dieticians, bacteriologists, almoners, masseuses. The central picture is of two nurses, the other pictures are connected to the central image by lines, much as in early chemistry lessons I was taught to draw atomic structures with a nucleus and orbiting spheres. Visually, nurses are shown to be the nucleus of the hospital team and the writing beneath the diagram confirms this, referring to the nurse as 'the vital link in the Hospital team'. It is worth noting that the nurses, unlike the other

team members, are not shown doing anything.

On page three, an elderly patient is shown receiving medication from a nurse, and the heading 'A distinguished career' is underneath. The reader is told that nursing 'offers scope for advancement rarely equalled in an ordinary job, as distinct from a professional post', and goes on to inform the reader about senior posts 'of great responsibility in the service of the nation'. Procedures for obtaining state registration are briefly described. Page four is headed by another photograph, this time of a classroom with Sister Tutor, in her Nightingale school cap and bow, teaching anatomy. (Uniform codes are discussed in more detail in Chapter 3.) A skeleton, a model of human abdominal organs and a large picture of the brain and its nervous system fill half the picture, whilst the other half is filled with rows of trainee nurses sitting in identical positions writing notes. The text is at pains to stress improved conditions of service and describes how time will be spent during training. At the bottom is a list of questions and answers...What happens if I fall ill, fail the exams, get married before or after qualification? The concluding paragraph assures the reader that 'the experience you have gained as a nurse will be of life long value' and, if you do decide to carry on nursing after you are married 'there are many openings available to you which you can combine with your household responsibilities'. On the facing page are brief details of the training schedule and training allowance. The final pages contain details of opportunities available after training, with a picture of a large group of nurses (perhaps at a graduation ceremony or similar event because they are not wearing aprons) looking rather like a drilled army in their uniformity. Rather than military aggression however, feminine passivity and acceptance seem to

be signified; the uniforms have the same collars and puffed sleeves as the cover girl. This perhaps demonstrates either a lack of individual female control in spite of the rhetoric of professionalism in the brochure, or an acceptance of the male / female hierarchies in health care and nursing's role within them.

Facing the picture of uniformity is a sketch of a nurse holding a child wrapped in a blanket with a bandaged head; in the background a child is sitting up in bed. Below it are details of two other ways to nurse 'if you do not feel able to take the three years' training for qualification as a state registered nurse. This is description of a two year training to become a state enrolled assistant nurse, and the details of pupil (as opposed to student) training allowances.

The photographs present an interesting formal contrast throughout the booklet to the informality of the sketches. In the drawings, which begin and end the booklet, the nursing figures look soft, small featured and feminine. The woman on the cover looks cheekily and invitingly out from the cover, confident and assured, her gaze meets ours. In the sketch on the last inside page of the brochure, the nurse holding the child has lowered lids, her attention is on the child, her dropped gaze posing a submissive, maternal look as she protectively holds the child, one hand adjusting the blanket. On the back cover, there is a return to the confident glance of the cover girl, only her gaze is directed slightly away from the reader, over the left shoulder. She is writing in fountain pen on a clip-board, looking cool, professional and detached. Adjacent is the invitation to become a nurse, and underneath the final image of her fastening her cape. The address is again direct, the features again

clearly those of the cover girl, but her eyes are smaller, no longer wide-eyed and innocent but slightly detached and aloof.

The photos, in contrast, are all very formally composed. The series of small photographs of the hospital team are all 'action' pictures, staged demonstrations of people doing their jobs. Photographic technology by the early 'fifties was however quite advanced. The formal style of these pictures, as opposed to the live action shots seen in magazines like **Picture Post**, indicates that deliberate choices were made about the kind of representations that were desirable. Whether the picture is of a group of nurses or a hospital ward, there is a uniformity of posture which suggests that these shots have been posed for, rather than that the sitters have been taken unawares. Everything is too rigid, too tidy...any hint of spontaneity is completely missing. Throughout the brochure, all the photographs share this formal style, which shares the same referential ethos as the films made specifically for recruitment purposes by the Central Office of Information, discussed in Chapter 1.

The overall message of the brochure through its images and words seems in some ways to be a contradictory one. The fun-loving figure on the front seems to disappear into a rather cool, more sophisticated creature by the final pages. A journey from innocence to experience is charted through images of training and discipline, the suggestion being that nursing will make you into a middle-class idealisation of feminine sophistication. No longer will you just be the ordinary 'girl next door', since becoming a nurse entails a change in social status, and with that status comes a confident aloofness and professional detachment.





Please arrange  
an interview for  
me to discuss my  
future as a  
**NURSE**

Name.....

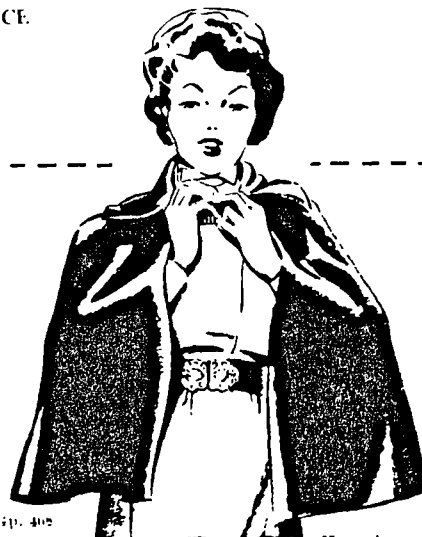
Date of Birth (if under 18) .....

Address .....

THE NURSING APPOINTMENTS OFFICE

(if here)

The noblest of all  
**SOCIAL  
SERVICE**  
for a woman



Printed by the Ministry of Health, May 1950  
No. 1484 P9101 100m 7 50 T. & B. Gp. 402

Plate 8: Back cover, 'Your Chance', 1950s.

In the post-war period, the government, through the Ministry of Labour, continued to produce information on careers for dissemination to schools, labour exchanges and career offices. **Nursing and Midwifery Services** (women) was 33 in the 'careers for men and women' series. The booklet has 38 pages, most of which are text, although photographs pepper some of the pages. The photographs are in many cases identical to the ones used in the leaflet discussed above, which seems to suggest that most of the material for the smaller leaflet was drawn from this one. Half of this publication deals with training, the rest of it with career prospects for qualified nurses and midwives both in Britain and abroad as a member of the armed forces.

In the introductory paragraph, the 'arduous' work and responsibilities of the training period are off-set against the numerous advantages to be gained by qualifying, when 'the field of opportunity open is so wide' that a nurse can 'give her best service' and find 'the deepest personal satisfaction'. As in other publications around this time, the last sentence of the introductory paragraph emphasises how useful her experiences will be to her as a wife and mother, whilst stressing that 'opportunities for work are not necessarily limited by marriage'. On this latter point, the booklet is however remarkably silent; it is clear from White's analysis of the system at this time that married women tended to be employed in the 'lower' grade of hospitals, those ran by local authorities, and had the lowest expectancy of promotion. Other married nurses found the district nursing services, school nursing, health visiting and midwifery far more to their taste than the rigidities of the hospital system.

The introduction emphasises the suitability of nursing training for ex-service women,

as well as women between the ages of twenty-one and twenty-six 'who will be more mature in their experience and judgement than girls fresh from school'. The advantages of being paid a salary, and receiving living accommodation, uniform, laundry and medical services free of charge are emphasised here - no doubt to point out the similarities between nursing training and the armed services. For younger women, details of pre-nursing training are given, particularly the pre-nursing courses which had been introduced as part of the general reforms in education during this period. These courses were run in some technical and secondary schools, some part-time, enabling prospective nursing candidates to work in useful occupations such as 'clerical work, nursery nursing or household duties'. In the **Sue Barton** books, there is a similar emphasis on the importance of accomplishment in household duties for prospective nursing candidates.

After the details of general training, specialised branches of nursing are described in detail. These include mental nursing, sick children's nursing, infectious diseases, tuberculosis nursing, and orthopaedics. The two year training as an assistant (state enrolled) nurse is covered in a brief paragraph, and emphasises that it is training for the care of the chronic sick and the elderly. 'It calls for a love of one's fellow beings, a high degree of patience and a practical trained approach to the many problems which arise in the course of the day's work'. For this kind of nursing work, the emphasis is on vocation and dedication rather than status or professional standing. Other forms of nursing available to the qualified candidate are then described in some detail - midwifery, district nursing, health visiting and industrial nursing. A number of paragraphs are devoted to work in the armed services, and

finally private nursing is mentioned. The remainder of the booklet is devoted to salaries, hours of work and superannuation; there is still no overall pay scale operating nationwide or set hours of work, in spite of war time efforts to establish uniformity. The government recommendation of 96 hours per fortnight 'should be worked in hospitals as soon as conditions permit', with examples of the types of salaries that 'are likely to operate in all hospitals and nursing services in this country'. The text points out that remuneration is 'as high as that in many other openings for women'.

The final paragraphs suggest that prospective candidates need to consult their head teacher or careers' mistress, or if you have left school, the Local Juvenile Advisory Committee of the Ministry of Labour and National Service or the Local Juvenile Employment Committee of the Local Education Authority. Alternatively, candidates could contact the nearest Nursing Appointments Office of the Ministry of Labour and National Service or the Nursing Recruitment Centre in London. The latter was organised by the nursing profession itself through the King Edward's Hospital Fund for London to deal with recruitment and training information for the London teaching hospitals. Their leaflets set a different tone to the government publications, partly because the earlier ones are entirely text-based and have no photographs. The basic information is the same, although the format used is that of a set of questions, 'How can I qualify?', 'What are the conditions?', 'At what age can I enter hospital?' etc. The leaflet produced in the early 'fifties emphasises the 'social value' and 'absorbing interest' of nursing but plays down ideas of vocation. Assistant Nurse training is recommended for those 'who would find state examination too difficult', rather than

as a separate sphere of vocational nursing tending the chronic sick and elderly, as emphasised in the Ministry of Labour booklet.

The question about educational standards emphasises the scope in the profession for those of 'marked ability and high educational standard', whilst pointing out that low educational attainment does not prevent a girl from becoming a nurse. The overall tone of the leaflet is however geared towards attracting those who are likely to have done well academically at school. Post-training opportunities are outlined in some detail, including specialist courses for ward sisters run by King Edward's Hospital Fund. Courses include management training, as well as specialist courses for nurse teachers and administrators. For those who want a home of their own, the advantages of district and private nursing are stressed. Diplomas in nursing are being given by this time by the universities of London and Edinburgh for those who wish to undertake advanced study.

The leaflet ends with details about the nursing recruitment service and their willingness to send speakers on 'nursing as a career' to schools in any part of the country. Full details of training allowances and trained staff salary scales are provided, with separate scales for women and men. Interestingly, even though the Nurses Act of 1949 has only just admitted men to the general nursing register, male staff nurses in general nursing start on a higher salary than their female colleagues, a disparity that is reflected at all levels of staff grading below nurse tutor. At the top end of the salary scale, a chief male nurse has a higher initial salary than a matron, although the wage scale for male nurses at this level cuts off at a lower point than

that for matrons. Although these wage differentials seem very minimal by today's standards (only £10 per year in a total wage of just under £400 per annum), the fact that they existed at all in a profession largely dominated by women is axiomatic of how little control the female leaders of the profession actually had during this period.

To sum up then, the Nursing Recruitment Service projects a very different image of the nurse to that on the front of the official recruiting brochure. The differences are most marked in relation to attitudes to the 'new' portal of entry created to the profession by the GNC in 1943 to recognise the grade of assistant nurse. These nurses worked in the municipal hospitals, caring for geriatric patients and the chronic sick. In the Ministry of Labour brochure, training for this grade is described beneath a picture of a nurse holding a child, emphasising the 'maternal' nature of this kind of work. Whilst the child can be read as an a metaphor for the helpless patient, for the girl who is thinking of becoming an assistant nurse, caring for children is probably a more attractive proposition than caring for helpless elderly adults, as Jeffrey's (1950) research indicated. This kind of nursing is however represented under the 'opportunities' section of the brochure for state registered training, where the nurse depicted is clearly in a position of authority, distributing medicines. At no point in any of the literature is there any indication just how separate these two strands of nursing are. Not only was training for each grade carried out in different types of hospitals, but the working conditions of the two groups were barely comparable. Whilst glamour and maternal values work hand in hand to indicate the feminine nature of the work on the brochure, the reality was that, for all its rewards,

the work was physically demanding and often 'dirty'.

It is this element of nursing work that the professionalisers have always sought to distance themselves from, seeking as White (1985) has pointed out, expertise in the area of acute care where curing has a higher value than caring, and personal autonomy is developed through specialisation. The Kings Fund brochure sets out the possibilities for continuing career development after qualification, clearly perceiving its reader as an academically motivated individual. The Ministry of Labour attempted to find a common denominator that would attract young women from a broader spectrum, using images familiar to readers of popular fiction interspersed with formal photographs, attempting to address a wide readership. Perhaps however there was another reason for the mixed imagery of the ministry's brochure. It is possible that the managers and the professionalisers, unable to agree, had compromised, thereby unknowingly creating an image of nursing that, through its very ambiguity, would feed popular fantasy and undermine the respectability that each of the nursing factions, in their own ways, had sought so hard to achieve.

It was not however only divisions between different classes of nurse that fractured professional unity; with the admission of men to the general registration roll in 1949, another powerful interest group quickly developed. This group are largely absent from both popular and professional images of the period, but their impact at all levels of the profession is significant.

### Part 3

#### Gender divisions: men enter the picture

The traditional gender divisions in health care place nursing as women's work, but there have always been male nurses - in psychiatric nursing, in the prison services and in the armed forces. Professionalisation in nursing developed however in the general nursing, an area dominated by women, and from which men were effectively excluded until the admission of men to the register in 1949. The issue of men in general nursing becomes much more prominent in the 1960s, and as a consequence men become more visible in the recruitment literature for general nursing, as well as for the traditionally male speciality of psychiatric nursing. How did this come about? Although they were admitted to the general nursing register in 1949, men were not permitted to join the Royal College of Nursing until 1960. Was the increasing visibility of men in the profession due to a small but vocal male faction who had made their way into the higher echelons of the profession by this time? As White (1985) notes, many men entered general nursing during the second world war via the armed services. At the end of the war, some of them switched to civilian nursing, increasing the percentage of men in hospital nursing overall, especially in the traditionally 'male' area of psychiatric care, but in addition the numbers of men in general nursing grew quite significantly.

Mrs Betty Hoare was Principal Nursing Officer (Education) at the United Liverpool Hospitals throughout the 1960s. In an interview discussing nurse recruitment, she pointed out that she had,



‘never worked with a male colleague in my training or subsequently until I went to do the sister tutor’s course (note sister- they were still called sister tutors in those days) between 1955 and 57. There were several men on the course and they had come from the psychiatric field and the general field - the ones in the general field had all been in the forces’ (January 1992).

Whilst on this course, she met Mr. Harry Rose, later to be in charge of recruitment for the Broadgreen group of hospitals in Liverpool. Mr. Rose was an army trained general nurse who held senior nursing rank in the RAMC. After the war, he had to find a hospital where men were accepted for general nurse training - at this time, there were about twelve in Britain and only a handful of hospitals employed qualified male nurses. He points out that the salaries for ex-service personnel were paid by a post-war government resettlement scheme. Hospitals with severe staffing problems tended to take advantage of the scheme and accepted male entrants, as well as trawling abroad for overseas applicants (Rose, personal communication, 1992).

Men entered general nursing through the former municipal hospitals, hospitals where it has already been noted there was a greater tendency towards unionisation amongst the rank and file, and a ‘managerialist’ ethos to the provision of nursing care in the hierarchy. By 1950 there were 25,600 male nurses in a total nursing population of 152,000...just over 16%. Five men were sitting on the General Nursing Council out of a total of 36 representatives - a very high proportion in relation to their numbers overall. Throughout the 1950s and 1960s, male nurses consistently achieved senior hospital posts in general nursing in spite of the fact that there were so few of them undertaking training. The reasons for this are generally attributed to the different

career aspirations of men and women in nursing. In their analysis of a group of male student nurses in 1968, Brown and Stones identified a difference in attitudes to nursing between male entrants and female entrants. Whilst educational background was a factor in male attitudes to nursing, it was a much less significant factor than amongst female recruits and school leavers. The male entrants, irrespective of educational background (although their education level was generally lower than that of female entrants), tended to see nursing as a career rather than a job or a vocation. Male trainees were more 'career minded', seeing a path of progression before them even before they had completed the basic training. As Brown and Stones point out, 'it could be that men needed the career image to rationalise and legitimise (to themselves and their peers) their decision to enter a field that, as they themselves said, was not thought of as a man's job and was moreover poorly paid' (Brown and Stones 1973: 80). Significantly, men who did not have a career vision tended to leave before completing their training, having decided that nursing was not for them .

Male entrants do seem to have been more career orientated than their female counterparts from the outset, no doubt because of their social conditioning which places an emphasis on the role of the male as economic provider, whereas there was still a clear expectation amongst young women that nursing was a 'fill-in' between school and marriage - a situation apparent in much of the recruitment literature as I have pointed out. This expectation certainly seemed to bear fruit for many young women; numbers of qualified female nurses dropped dramatically after the age of 25 or so, the very age at which promotion and progression started to be considered.

Since men were (and still are) highly likely to stay in the profession once they have trained, they quickly became over-represented in middle management levels in relation to their numbers overall. As Brown and Stones point out,

‘Men offer an important alternative to the traditional spinster in all fields of nursing...marriage is more likely to bind men to a career than to wean them from it...once trained (men) can be counted as permanent additions to the hospital nursing staff’ (1973: 25).

Male recruitment was actively revived in 1968, no doubt in part due to the recession; during the 1930s, large numbers of men had sought nursing posts (Brown and Stones 1973: 109). In casual conversation with male nurses on the wards in the 1980s, many of them claimed to have entered nursing due to a lack of other job opportunities in their immediate geographical area. Their choice of nursing therefore reflects work patterns in other areas of the economy - when jobs are in short supply, men take over the low status work that has traditionally been done by women.

Nonetheless, the most clearly favoured recruitment group in English hospitals during the 1960s continued to be young unmarried women with middle-class backgrounds, grammar school educations, and English parentage (Jones [1967] in Brown and Stones 1973). Before concentrating on the images used to recruit men to the profession, I shall examine the changes in the materials produced to attract this ‘ideal type’ for state registered training, and compare them with those used to attract her less educated counterpart for training for the roll.

## The Nursing Recruitment Service

By 1965, the Nursing Recruitment Service had updated their recruitment literature very moderately. Perhaps they still felt that the reasons for maintaining a separate recruitment service to that run by the Ministry of Health were as pertinent as they were in 1943, when recruitment was first taken over by the Ministry of Labour. The Service can certainly be seen as a way of maintaining a particular image of professional identity at a time when the former voluntary hospitals, traditionally trainers of the leaders of the nursing profession, felt themselves to be under threat from the government's image of nursing. The recruitment leaflets produced by the Ministry of Health were not, as Mrs Betty Hoare pointed out at interview, an image of nursing approved of or used for recruiting people to the traditional centres of excellence. The Nursing Recruitment Service therefore continued to provide publications for these institutions, presenting nursing as a distinctly professional career for young middle-class women.

By the 1960s there were some significant differences between their own earlier publications and the updated version, the most obvious being the addition of a picture on the front cover of the small brochure **Nursing Today**. It features a nurse sitting at a desk writing, her face and hands illuminated by a pool of light from an unseen desk lamp or similar light source. The framework of reference is quite unmistakable: here is the 'Lady of the Lamp', sitting with a concentrated air of autonomous authority, writing. As in many images used in recruitment literature up until this time, there is no sign of the patient; the focus is on the nurse as an embodiment of a particular set of ideas and values. The discourse inscribed on the image of this

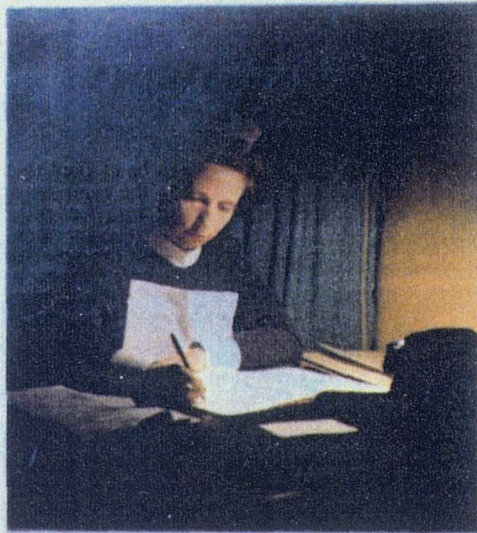
woman, with its unmistakable reference to the Nightingale ideal, emphasises education and scholarship, drawing on professional nursing's growing promotion of Nightingale as an administrator and a leader. This 'model' of the professional nurse wears the trappings of vocational nursing, the white starched apron of a Victorian maid, and a small lace hat perched on the top of her head but for those experienced enough to be able to decode nursing's hierarchical symbolism, she is at the very least a sister, epitomising an ideal of female authority based on the notion of service - a 'sixties version of the traditional 'angel of mercy'.

From a closer look at this brochure, it is possible to deduce who is likely to respond to its interpellation, who might be hailed by that image and think 'that could be me'. Inside, the brochure is laid out similarly to its predecessor, using a question and answer format. On page 2, 'Nursing Today' replaces 'The Nursing Profession' as the header. Instead of the former emphasis on social service with its associated implication of nursing as women's work in the phrase 'A girl who enters the nursing profession undertakes work of great social value', there is a less directly sexist and more individuated opening address; 'People who become nurses can be assured that their work will be of real value to the community and a source of happiness and satisfaction to themselves'. The 'social' has been replaced by the concept of 'community', a word that as Raymond Williams (1976) pointed out, has never had an unfavourable connotation although who or what that community is or might be is left for the reader to deduce since it is used without contextual qualification.

Reading this brochure, it is clear that the 'people' who can be nurses are still in fact

women, and these women serve an unknown 'other', the idea of 'community'. The second sentence of the brochure is remarkably similar to its forerunner, apart from small changes in emphasis. No longer do nursing and medicine contribute to 'the health services of the nation', but to the 'well-being of all'. The nationalist ethos of post-war Britain implied in 'serving the nation' gives way to the rhetoric of consensus politics in the phrase 'mutual well-being', and begins to indicate a changing conception of the role of the professional nurse. The new wording emphasises the separate but equal contribution of doctors and nurses to well-being, the implication being that nurses too are actively involved in the process of health care. As Elizabeth Wilson (1980) points out in her analysis of women in post war Britain, the literature on marriage also changes to a rhetoric of partnership and co-operation, with an increased emphasis on togetherness, an updated middle-class ideal of separate spheres replacing the pre-war notion of women servicing the needs of their husbands. Given a model of health care with its roots in rigid gendered divisions of labour, it is unsurprising to find the rhetoric of professional nursing using the same metaphoric language as that of the literature on marriage. The small changes in the brochure can be seen as part of a more widespread cultural change in the discourse on women's role, rather than an active pursuit of change per se by the nursing profession. The overall message of this brochure is very similar to that of its predecessor; to do interesting nursing work, you have to be both educated and qualified (i.e. state registered). Although the role of the professional nurse is changing, the changes are as much based in a changing conception of woman's role in society and changes in the medical treatment of ill health as in the nursing profession's perception of the changing role of the nurse in an increasingly complex society.

# NURSING TO-DAY



NURSING RECRUITMENT SERVICE  
(King Edward's Hospital Fund)  
6, CAVENDISH SQUARE  
LONDON, W.1.

*Plate 9: Front cover, 'Nursing Today', 1960s.*

The terms of address of the brochure become clear within this context. This is not a document aimed at recruiting women for the rank and file of 'general' nursing, still less for attending on the chronic sick. This is the portal of entry to the most interesting (and by implication, the highest status and most economically rewarding) nursing work. The brochure is aimed at those with ambition, those who are more likely to be attending grammar schools or who are already in higher education. The Kings Fund, as an organisation, has always had a close association with the London teaching hospitals - St. Thomas's (the original home of the first Nightingale School of Nursing), St. Bartholomews (Barts), and Guys are perhaps the most famous - and it is these (former voluntary) hospitals whose interests and traditions the Kings Fund sought to promote and protect. It is in these hospitals that the future leaders of the profession were traditionally trained, and it is to academically bright young women who might consider nursing as a career rather than just a job that the brochure directs its address.

Nowhere in the recruitment literature are the changes in nurse education mapped so clearly as when these two documents from the 1950s and 1960s are set side by side. Whereas previously it had been possible to train for state registration in the numerous branches of nursing, now students are advised to start with a general qualification, since it is necessary for the majority of all senior posts. General nursing's progress towards hegemony in the education sector can by this stage be seen to be completed. Experimental combined courses are mentioned, which result in joint qualifications in two fields after four years. Attention is also drawn to the new courses which combine general nursing and midwifery with public health and district nursing. Degree courses



in Manchester and Edinburgh are available (but not in London, due to friction between the Royal College of Nursing and the University of London over course content). All the integrated and experimental courses demand university entrance standards. Some shortened courses are available for graduates and others with comparable educational requirements.

Within the context of general nursing's hegemony, it is clear that 'the professionals', those in favour of developing a knowledge base for nursing on the scientific (biomedical) model, have by this time made sufficient headway within nursing structures to begin to seriously challenge 'the generalists', those in favour of basic training only. New training courses expanded throughout Britain during the 'sixties as the professionals began to exert a stronger influence within the Royal College of Nursing. The College's commitment to education and training was written into its charter, a fact the professionals' became increasingly conscious of and used to their advantage. Tutors began to seriously rival the matrons as progenitors of occupational ideals as the matron elite became increasingly frustrated with their position in the new NHS management structures. The grouping together of hospitals to rationalise services had shifted the centre of decision making in the voluntary hospital sector from the hospital board to the Group Secretary; matrons, accustomed to representing nurses' interests at hospital level, were often excluded from management decisions and lost the direct consultation at managerial level that they had previously enjoyed (Carpenter, 1978; White, 1986a).

Disconcerted at their loss of power, the matrons agitated for reform, channelling their

discontent through the Royal College. This led to the setting up of the Committee on Senior Nursing Staff Structure (Salmon), on which the RCN had a majority voice. The Committee reported in 1965 with recommendations for a modern management structure which it was hoped would restore morale within the profession and provide a clear career structure, the latter acting as an incentive for retaining trained staff in the profession as well as boosting recruitment. It was hoped that the new career structure would attract back to nursing the young middle-class women lost to nursing due to the increasing number of career opportunities becoming available for them by giving nursing an up to date, modern image. The new structure of management created by Salmon had however at least one unforeseen effect; it opened the door to career orientated male nurses, a point I shall return to later.

Other changes in evidence in the training structures concern the provision for those leaving school at 15 or 16 who want to be nurses. Pre-nursing courses, recognised conjointly by the GNC and the Ministry of Education, were by this time widely available in numerous secondary schools. Many of these courses led to exemption from part 1 of the State examinations. Exemptions from part 1 were also possible for those who had passed human biology or human anatomy, physiology and hygiene at GCE ordinary level. There is less emphasis in this section on the value to nursing of the traditionally 'feminine' skills of mothercraft, household management, nursery nursing and clerical work. After outlining the numerous hospital cadet schemes available, brief mention is made of secretarial and domestic science courses. The only reference to anything approximating housework as useful experience prior to taking up nursing is 'au pairing' in other countries. There is a clear enabling ethic

in the brochure, and much of the rather severe authoritarian tone of its forerunner has been modified.

Conditions of service are clearly more attractive than in the 'fifties, with the 96 hour fortnight becoming a 42 hour week. The six weeks annual leave for all trained staff looks generous, even by today's standards. The brochure claims that it is possible to live out whilst training, although this was totally dependent on conditions at individual training schools and seems to have still been a relatively infrequent practice. After details of opportunities post qualification, a brief paragraph is dedicated to male nurses. Throughout the brochure, boys and men have had sporadic mention, usually in connection with the traditionally male field of mental nursing. The brochure points out that many hospitals now accept small numbers of men for general training, who are expected to be non-resident. Careers are opened to men in all branches of nursing; the detail is however scant, and the general impression is that boys and men were not being encouraged to take up general nurse training, especially in the teaching and former voluntary hospitals. (The London teaching hospitals admitted men for the first time in 1966.) The emphasis is still on 'the large part (that male nurses play) in the staffing of hospitals for the mentally ill...where training allowances and salaries are higher'. It is clear that even by the mid 'sixties, the traditional division of labour in nursing care was still firmly entrenched and showing little sign, at least in professional nursing recruitment, of shifting.

Other material produced at this time by the Nursing Recruitment Service emphasises the modern ward environment. The architecture and furniture of hospital wards is

often neglected as a significant factor in recruitment literature, the emphasis falling on 'modern' conditions in nurses homes in an attempt to over-compensate for their pre-war authoritarian image. As Karen Kingsley points out however, 'the built form reflects the social and cultural position of nursing' (Kingsley, 1988:63). In the brochure **Your Life in Nursing** the ward depicted has an intimate feel in comparison to the long 'Nightingale' wards built in Victorian times. The bright curtains and flowers are a welcome visual distraction in the rather sparse environment, which shows four or five patients lying in their beds with two nurses and a white coated figure attending them. A large picture of a young nurse occupies the left-hand foreground. She gazes directly out from the page, appearing neither coquettish, nor coy, but serious and rather business like, with a hint of humour in the slightly turned up corners of her mouth. Her uniform is a modern variant of the traditional format: white collar, apron and cuffs on a short-sleeved pin stripe button-through dress. Her hat sits neatly and unobtrusively on the back of her head. This rather ordinary looking young woman has perhaps been chosen as a suitable image for the brochure because of her serene quality. Placed as she is on the page, over-lapping the main picture of the ward, she seems to belong to her environment in a quietly authoritative manner. Nursing seems less dominated in this image by the traditions of the past and is more integrally constituted as part of modern hospital life.

### **The Ministry of Health**

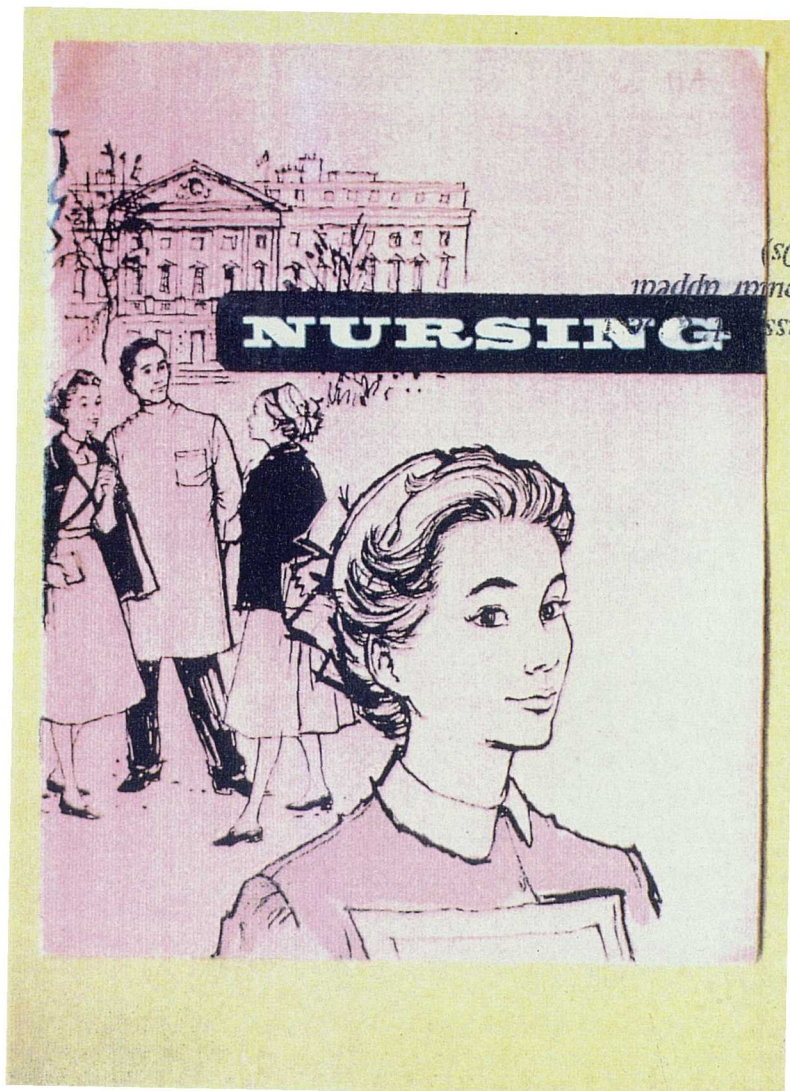
By the mid 1960s, the Ministry of Health and the Ministry of Labour were still jointly producing nursing recruitment materials. Leaflet NL. 013 **You want to be a Nurse? Your Questions Answered** is firmly in the tradition of its postwar predecessors,

using cartoon sketches to create broad, lightweight appeal. The leaflet stands out because it is pale blue, in contrast to the black-and-whiteness of earlier publications. This has the effect of emphasising the comic nurse figures. The basic format is of a list of twenty questions with small ink drawn cartoon sketches in the margins. The sketches parody patients, doctors and principally nurses in a variety of 'typical' situations - taking a temperature, attending to a mother and baby, attending lectures, relaxing in the nurses home, and last but not least, standing alone with a halo! The lighthearted, fun approach creates an air of contemporariness and is similar to the cartoon style used to create the title sequence for the popular British **Doctor** films; no longer is nursing stuck in the authoritarian ways of the past, it is a lively jolly job where there is even time to stand around and talk to your (medical male) colleagues. It seems likely that this brochure would have been used to try and appeal to those who may not necessarily be considering a job in nursing. By this time, nursing was having to compete with other para-medical specialities such as physiotherapy and radiography for their share of the female labour market and had to take a more active, campaigning approach to recruitment. As I have pointed out, this was not an image of nursing favoured by the former voluntary sector and seems much more likely to have been used by the former municipal hospitals, where there continued to be acute staffing problems.

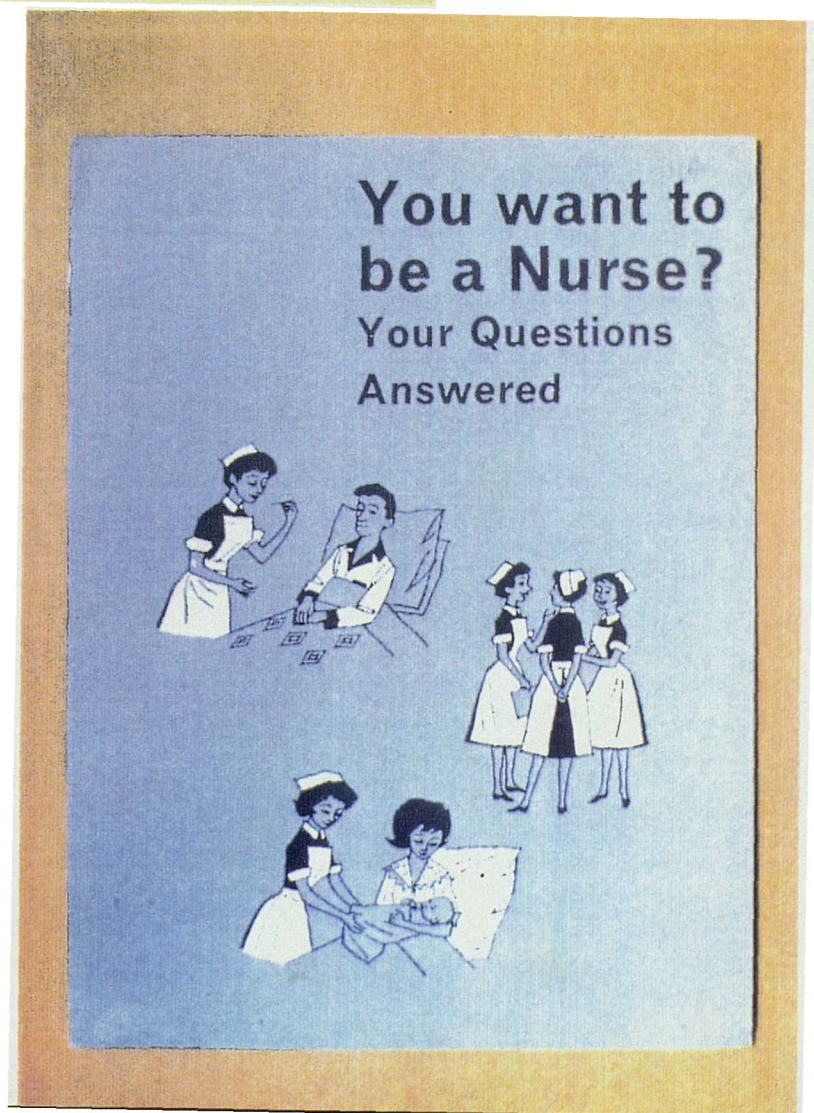
During the same period, a brochure was circulating that clearly had more serious appeal. Again, it has a drawn cover, but this time the background paper is pink, and the style of line drawing resembles the kind of image that young women were accustomed to seeing in popular girls magazines like **Bunty** and **Judy**. These

magazines often had heroines who were highly active and successful, stressing individual achievement in fields like horseriding, skating, ballet and acting. The **Sue Barton** series had reached mass popularity in Britain by this time; the nurse on the cover of the brochure is a 'Sue Barton' look-a-like, neat, professional and feminine but with no hint of sexual appeal. She is a modern image of asexualised femininity, placed in relation to a large, Palladian (classical) building, with a group of friends carrying books. She is accompanied by a man, clearly signalled as a nurse by his white buttoned tunic. This is a re-formulation of the front of the 'fifties careers brochure using the same classical signifiers to suggest knowledge and professionalism. Like its predecessors, it is illustrated throughout with carefully posed photographs that show the various faces of nursing. Although there is a new emphasis on technical procedures, the overall impression is one of traditional values; concentrated faces lit by a desk lamp on night duty, mothering a small child, protectively watched over by a doctor/ teacher, assisting the doctor in theatre. In the nurses home, women (again, the nurses depicted are all female apart from the figure on the cover) sit and play records and dance - the shortage of male partners is noticeable. At the end of the brochure is a brief note telling young men to look at leaflet NL.09, and if you want to become state enrolled, leaflet NL.011a.

Addressing as it does the lower middle-class teenage readership of **Bunty** and **Judy**, the girls who are likely to be doing well at school as a result of the new meritocracy in education, the leaflet stresses that a first class training is available not only in London and the large cities but at over 400 regional hospitals; 'there is certain to be one within fairly easy reach of your home'. Clearly, attempts were being made to



Plates 10: 'Classical' appeal  
 Plate 11: 'Popular' appeal  
 (1960s)



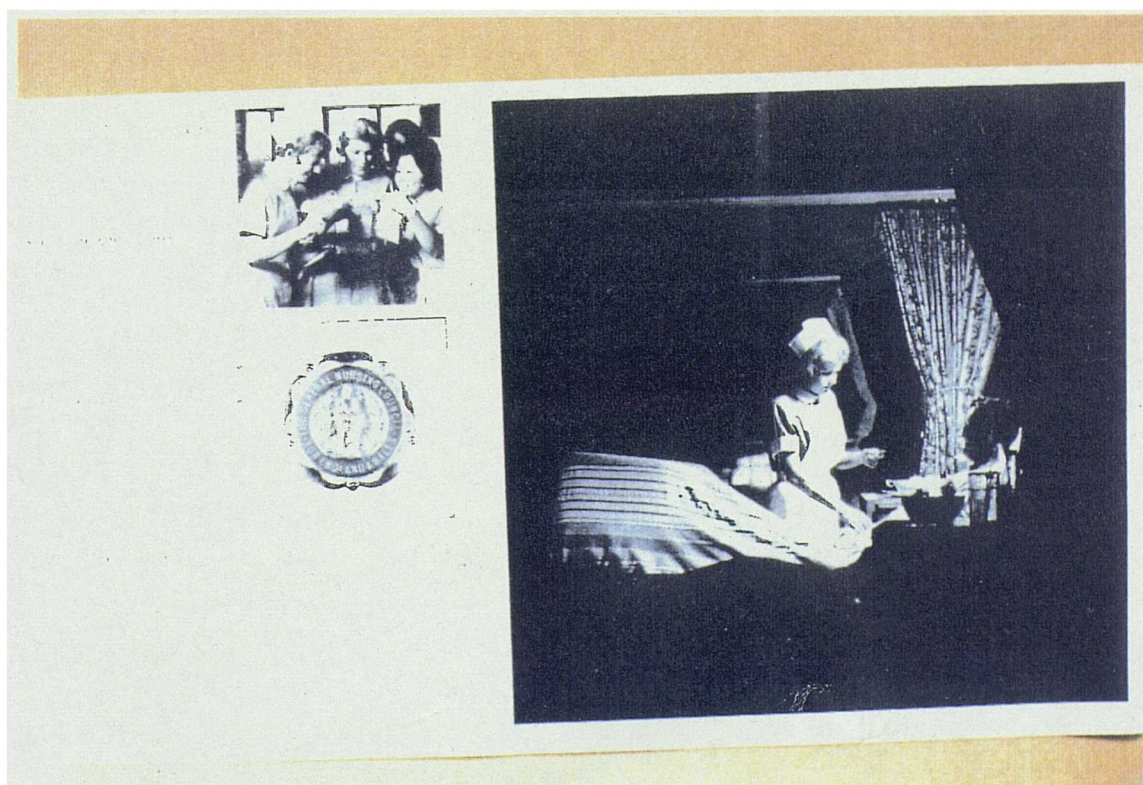


spread the notion of excellence attached to the London teaching hospitals and their nursing schools throughout the regional hospital system as re-organisation of the health service sought to erode traditional centres of medical power in the interests of a more equitable distribution of services.

Two rather glossy brochures were also produced around this time that signal a new consciousness in government publications of the importance of images, adopting currently fashionable modes of presentation from popular magazines and advertising. These brochures foreground the use of photography far more consciously than their predecessors, using documentary and photo-journalist techniques. This style of photography, long favoured by quality news publications, attempts to capture 'life as it is', preferring to shoot live situations rather than setting up posed tableaux. The overall effect is to inject a sense of urgency and dynamism into the depictions of nursing work. Whereas previously pictures had served the purpose of illustrating particular situations and tasks, now the emphasis is on using the picture to tell the story, with short captions to guide interpretation.

The full colour cover of the state registration brochure, labelled simply **SRN** in bright red lettering, shows a young woman in full uniform against the blurred, obviously moving, image of an ambulance behind her. This sense of movement and urgency continues in the black and white photo narrative that illustrates the process of training from the first interview with matron to the final images of 'high tech' medical care. Inside, a full page photo depicts the nurse looking at a white coated male figure against the background of the ward, with a patient clearly visible. Against





*Plate 12: A new urgency and drama, 'SRN' 1964*

expectations, the man in the white coat is not a doctor but a charge nurse, her immediate superior and in charge of the ward team. This is however the only depiction of a male nurse in the brochure; the same image was used in a cropped version on the front cover of **How to Become a Nurse, a brief guide for men and women**, leaflet HSC 102. The presence of men in general nursing is clearly signalled, as is, later in the brochure, the presence of a non-white nurse in training - the first time such images have appeared in any of the recruitment literature.

In this brochure, photographs dominate the written word. The story of Patricia Dyer's training is mapped in captioned black and white documentary style photos which emphasise varied work with patients, much of it looking fairly technical. The patient is clearly the centre of nursing work...or rather, the body of the patient is the focus of attention, since on many of the pictures the face cannot be seen. The effect of this dismemberment is to present nursing as a series of tasks performed on the body, whilst never revealing the potential distastefulness or personal nature of many bodily functions. Objectification works hand in hand with melodramatic lighting to create an atmosphere similar to the popular television medical documentary series, **Your Life in Their Hands** (BBC 1 1959-63). Anne Karpf comments on this series, 'the patient is scarcely seen, merely a slab of flesh under the gown' (Karpf 1988: 55). This was the period when television concentrated on the dramatic, life saving aspects of medicine - values that are being exploited here by nursing recruiters.

The overall tone of this brochure is completely different from its forerunners because of its visual qualities - apart from the personalised narrative, the presentation of

information is similar to that in previous publications. As a result, the emphasis is on the role of the nurse in saving and preserving life, making nursing 'surely the most rewarding job in the world'. The information about training follows the narrative of the photographs, explaining the different stages leading up to state registration. There are few headings, so the one labelled 'training after marriage' clearly stands out. For the first time it is theoretically possible to marry during training and live out, although in practice this was still discouraged in many training schools.

A separate brochure was produced to recruit trainees for the roll, **Proud badge of service: A close look at the rewarding job of an Enrolled Nurse**. Again, there is a colour photograph cover depicting an attractive 'Audrey Hepburn' look-a-like model pinning a badge to her uniform. It is interesting to note the very different discourse around nursing clearly apparent in the brochure. Although a similar photo-narrative technique is used to illustrate the training process, it lacks the intensity of the SRN brochure. The photographs are less dramatically lit, showing tasks performed in a modern hospital setting. Sketches tend to undermine the seriousness of the brochure, creating an impressionistic light-hearted approach to the subject and removing much of the dramatic intensity achieved by the documentary photo-narrative. The first page contains the rather surprising words, 'She may or may not be a natural beauty. Either way, she's attractive to everyone because she's confident and poised', with a photograph of a back view of a nurse walking away from the camera. This is followed by the caption, 'Two years practical training made an SEN of this girl', adjacent to a close-up of a rather cheeky looking young woman

with buck teeth. The sub-text is clear; you don't have to be physically attractive to be a nurse! The text goes on to point out the 'ordinariness' of this girl, ending the narrative of training with a set of photos that include a wedding - only the bride is a rather attractive blonde! This brochure falls uneasily between popular fictional and comic portrayals of nursing and romance, deliberately juxtapositioning a romantic ideal of feminine beauty and marriage with the alternative of nursing. On the last page of the brochure, these two positions are reconciled at the level of the image by sandwiching a picture of a girl getting married between the two images of the girl with buck teeth and a text that can be summarised as 'married or not, you'll always be in demand'.

### **Recruiting men to general nursing.**

Between 1950 and 1971, the increase in staff levels in mental illness hospitals was less than 5% compared to a 79% increase in general hospitals. Clearly, the area of general nursing expanded rapidly, whilst the psychiatric sector, traditionally an employer of male nursing labour, grew very little. It is hard to estimate the extent to which increasing numbers of male nurses in senior positions in general nursing influenced recruitment policies, but by 1968 men were being actively sought as student general nurses in the face of continuing attrition by females. This was in spite of the fact that boys leaving school had very little interest in nursing, a situation that some of the men in nursing hoped to change. A 1966 survey of English school leavers did not find a single boy who said he intended to take up a career in nursing (Government social survey, *Young School Leavers: An enquiry for the schools council*, 1968), but Brown and Stones' (1968) survey of male student and pupil nurses





Plates:13 & 14: Cover and page 1, 'Proud badge of service'.





Two years'  
practical training  
made an S.E.N.  
of this girl

This girl was not extraordinary until she made one of the most important decisions of her life—to enroll for training as a State Enrolled Nurse. She had a good general education—but no special examination qualifications. She was in good health (even better, now) and she had the most important qualification—a desire to lead an interesting life in a really worthwhile job. She knows that her work is vitally important—and she wears her badge proudly.

She could be YOU • The following pages will show you how



The end-  
and the  
beginning

Undoubtedly the gaining of her S.E.N. badge is a moment of considerable pride to the successful Pupil Nurse—and to her family and friends. But entry into the Roll of Nurses brings more than personal pride and satisfaction. It is the real beginning of a life-long career of inestimable value to herself and her community. The State Enrolled Nurse can, and often does, marry and raise a family of her own. In her home life, naturally, her training is of vast value. And, as her family grows up, the State Enrolled Nurse often returns to the satisfaction of her profession and the pleasures of a second family income—a move denied to many married women. She knows that she will be financially secure—always in demand.

Plates 15 & 16: Page 3 and final page, 'Proud badge of service':

found that nursing was attracting both job seekers and fresh career men. These trainees saw nursing as a worthwhile, useful job, and did not share the popular view of the nurse as a self-sacrificing paragon. Neither, according to Brown and Stones, did they see themselves as impersonal nursing technicians. These men were far more career motivated rather than vocationally orientated in their outlook, and it is the career possibilities in general nursing that are emphasised in the recruitment literature.

By the late 1960s, these brochures are clearly working in antithesis to the feminised images of nursing depicted in the literature aimed at young women. One brochure depicts a man in a suit, coat over his arm, walking through a high rise cityscape with other men carrying briefcases. 'He's stepping out in a career that's different', claims the caption heading (1970), whilst never hinting that this difference entails swapping the office and the suit for the ward and a white tunic. The use of a man wearing mufti clearly avoids the issue of how to represent the male nurse at a time when men in general nursing were often considered by many members of the public to be, at the very least, effeminate, more often homosexual. Although there is no mention of this problem of public attitudes in Brown and Stones' (1968) study of peer group attitudes to male nurses, the question of sexuality is clearly significant and must be taken into account in any analysis of images of men in general nursing.

At around the same time, another leaflet was produced that went into the prospects for male nurses in more detail. Again, the cover avoids any direct association of the word nurse with any kind of nursing image by using clear bold lines of typeface, with

the word 'nursing' sandwiched in between them, outlined in orange, virtually filling the page. What catches the eye is the strong black lettering, particularly the word 'men' which is in bold black capitals. It takes another look to register 'nursing', by which time the words 'a career with status and prospects' may well have encouraged a job seeker to pick it up.

On the first page inside this brochure, three men are pictured in discussion with a female colleague. The text opens with, 'The history of medicine and nursing as the twin arts of healing goes back to ancient times...today, the part played by men is of vital importance'. The brochure quotes numbers of men in nursing, their distribution in different specialities, and stresses that increasing numbers of the highest positions are held by men. Women are pushed out of the picture in this brochure, both in the text and in the photographs where they are marginalised to the edges of the frame. As in the SRN brochure aimed at women, there is an emphasis on the technology of nursing care, on the complexity of modern medicine, and in this brochure on the role that men can play in both general and psychiatric nursing. A clear split in representation is apparent between the two fields of work. Whereas general nursing is presented as 'high-tech' curative work, psychiatric nursing is presented as 'caring'.

Brown and Stones found that most of the male trainees they interviewed had actively sought a career in nursing, in the main by responding to newspaper advertisements. Many had family contacts with nursing or hospitals and had been members of organisations like St. Johns Ambulance. They had decided that nursing offered attractive career possibilities on the basis of their general knowledge. Most had



humbler origins than female trainees and fewer formal educational qualifications.

‘Their image of nursing in general...is fairly realistic and down to earth. The men did not share the general public’s view of the nurse as highly intelligent, dedicated and self-sacrificing. Nursing was a useful and practical skill which could be learned’ (Brown and Stones 1973: 114).

The men seem to have adopted a functionalist approach to their choice of career at a time when traditional avenues for semi-skilled and skilled training in industry were becoming less available. Unlike their female counterparts, ‘it was noticeable that none of the men, when asked about their future career, showed reluctance to be promoted to posts of responsibility which would take them away from bedside nursing - a stumbling block for many women nurses’ (ibid).

It is important to note that the men entering nursing for state registration (general) training had fewer formal educational qualifications than their female equivalents; if they had been female, it is possible they might have become state enrolled rather state registered. As it is, the state enrolled nurse, who is invariably female unless he is black, continues to administer ‘tender loving care’ at the bedside whether he or she is young or old. By 1971, enrolled nurses accounted for one qualified nurse in three, and pupil nurses accounted for nearly a third of all nurses in training. When Brown and Stones argue that the female composition of the hospital workplace is a result of specific historical circumstances, they are right, but their analysis is based upon essentialist claims and a rationalist logic that argues for the suitability of nursing as a career for men as it becomes more technical and scientifically based. Although Brown and Stones’ respondents saw themselves as ‘caring for’ rather than ‘curing’

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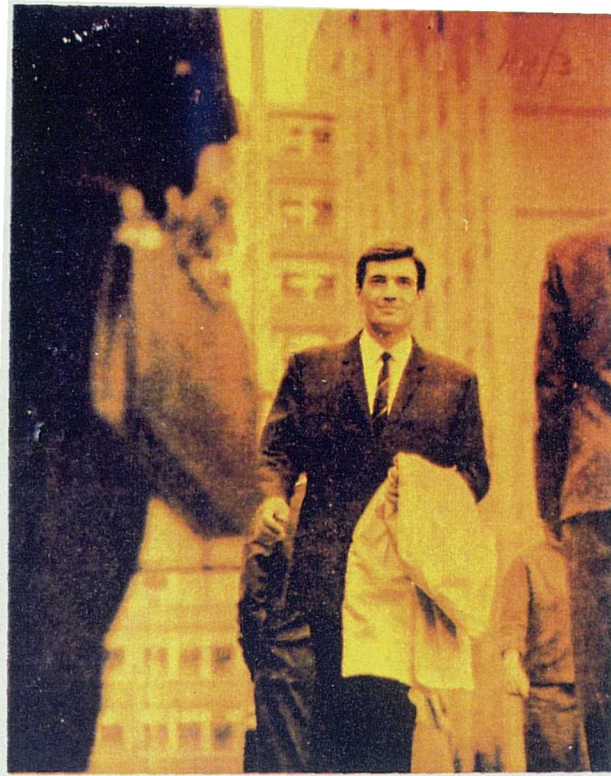
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patients, their sample is to some extent confusing because the majority of interviewees worked in the psychiatric sector, where custodial care or managing the patient played a dominant role in the nursing process. In the recruitment literature, as I have already pointed out, it is the high-tech specialist 'curing' aspects of work in general nursing which are particularly advocated for men, whilst the 'caring' aspect is portrayed in relation to work with mentally handicapped adults and the psychiatric sector. Caring in general nursing remains firmly within the province of state enrolled nurses and auxiliaries - areas where men were not actively recruited.

In their book on the male nurse, Brown and Stones comment that:

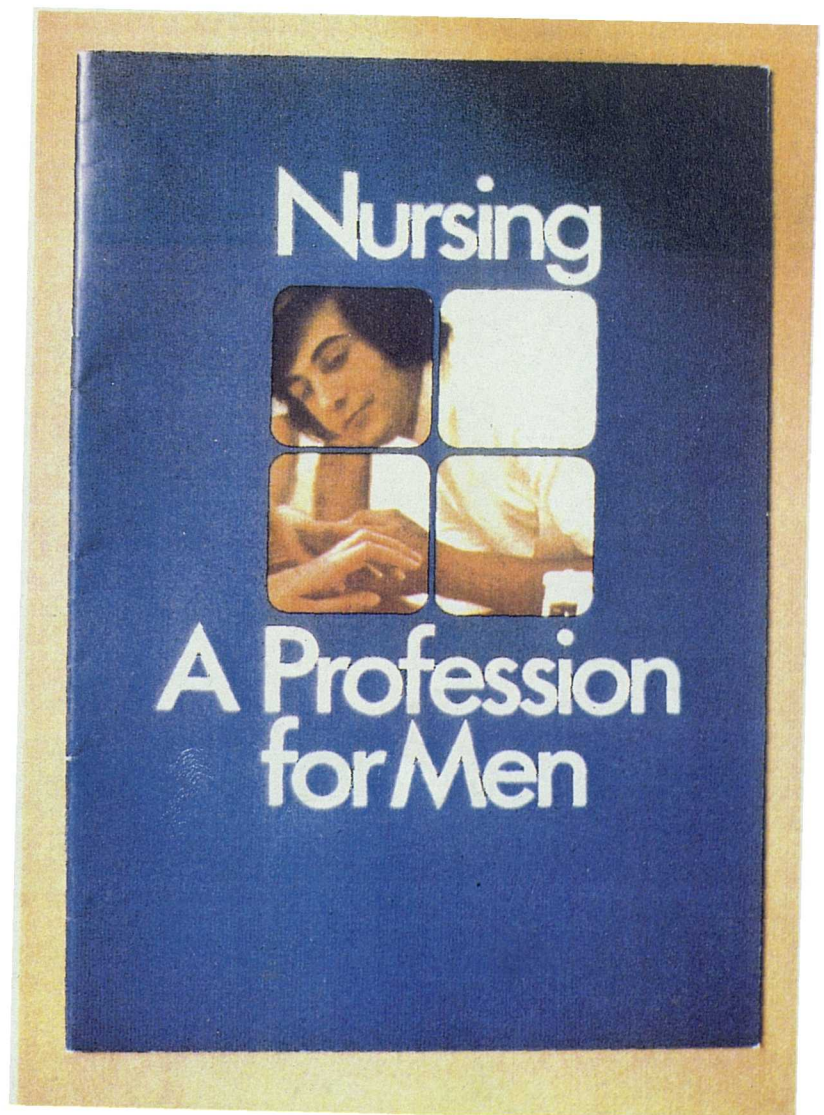
'Although there is still a need for the tender loving care traditionally rendered at the bedside by young female nurses there are many other demands on nursing staff. The technical advances required to keep pace with medical developments and increasing specialisation demand types of ability and aptitude which may be found as readily in men as in women ...Some have argued that men bring a kind of emotional objectivity and technical ability which is ideally suited to the modern world of nursing' (1973: 14).

In both the recruitment literature and the commentary written around male nurses a discourse of professionalism is assumed which values technical nursing work. Never is there any suggestion that the 'tender loving care traditionally rendered at the bedside by young female nurses' could also be done by men. Practical work (the sub text here is 'dirty' work) and emotional work is left to others - primarily the SEN or the nursing auxiliary, the vast majority of whom are women.



He's stepping out in a  
career that's different

*Plate 17: Late 1960s.*  
*Plate 18: Mid 1970s.*



In her study on nursing and gender issues, Salvage (1987) points out that nursing autonomy and professionalisation are increasingly associated with masculine values of emotional objectivity and technical ability. These values have been extensively promoted by an emphasis on academic and scientific education at the expense of learning from the expertise of practicing nurses, a problem I discuss further in Chapter 3.

Recruitment for men during the early years of the 1970s continued to emphasise the differences between curing 'high tech' general nursing and 'caring' psychiatric nursing. A later full colour brochure, **Men in Professional Nursing**, (1974) attempts to create a high-tech look for nursing through its use of graphics, but the image is somewhat undercut by the mid 'seventies image of masculinity. A male nurse is depicted on the cover undertaking a nursing task. A square screen border is used to break up the photograph and frame it, dividing the picture into four sections. This creates the effect of a close-up of the man's face as he bends over inspecting a pair of hands. In discussion with students, it is undoubtedly the fashionable (for the time) long hair in conjunction with continuing unconsidered prejudices about men in nursing doing 'women's work' that contribute to a reading of this image as one of a gay man, an image problem that must have continued to influence male recruitment at this time in spite of slightly more liberal ideas towards sexuality beginning to percolate through British society.

In their report on male nurses, Brown and Stones identified several major steps that in their opinion needed to be taken in order to make nursing a more attractive career

option for men. Significantly, none of them address issues of sexuality. Firstly, they see the recruitment process as haphazard in its organisation, especially in relation to the recruiting of young men. The efforts that were being made to reach this group were deemed inadequate and insufficient. However, no detailed analysis of recruitment processes is provided to support their point, and no analysis of existent recruitment materials accompanies their critique. Secondly, they stress the need for advertising the career paths available in nursing, particularly in relation to the changes in senior staffing structures brought about by the introduction of Salmon, which favour a path of basic (general) training followed by management training. This point was of course equally applicable to the recruiting of women. Many of us who trained in the early 'seventies had no idea of the career routes available to us beyond the obvious level of ward sister or charge nurse, as the interviews in Chapter 3 confirm. Thirdly, they recommend a general assessment of male candidates based on their previous history and their knowledge of and motivation towards a nursing career. Men who did not complete training were often those with a history of uncompleted training and/or unemployment. They point out how numerous male overseas recruits tend to get relegated to pupil nurse status when they have the capacity for student training. As I will point out later, this was also equally applicable to women from overseas. Fourthly, they maintain that there is a good argument for concentrating the training of male nurses in selected hospitals where the peer groups would be larger. They recommend special arrangements for more mature candidates so that they can develop their full potential, and for those from overseas who have to contend with cultural difference. Again, these points are equally applicable to mature female applicants and women from overseas, but Brown and Stones are clearly in favour of

a degree of sexual segregation.

By 1972, 270,293 (89%) of the 304,834 staff in NHS hospitals in England and Wales were women, including auxiliary nurses and trainees. The male share of the workforce had fallen in real terms from 16% in 1950 to 11%, whilst numerically the workforce had doubled in size. Nonetheless, in spite of their smaller overall proportion in the workforce, between 1969 and 1972 in all types of hospitals the number of men in the top two grades of Principal Nursing Officer and Chief Nursing Officer increased eightfold, compared to only fivefold for females. (These posts were created as hospitals changed their nursing management systems in line with the recommendations made by the Salmon report, 1966). Salvage notes that 'in 1980 almost half of the most senior nursing positions in management, education and various professional organisations, trade unions and statutory bodies concerned with nursing were occupied by men, although in nursing as whole, men constitute only 10% of the workforce' (1985: 68). The cumulative effects of the male career path in nursing are clear; men become managers and professionalisers in inverse proportions to their numbers overall. The division of labour in health care, formerly operating between doctors and nurses has become integral to a division of labour within nursing itself with the rank and file, those who do much of the 'dirty' work of nursing, remaining overwhelmingly female. Unsurprisingly, as more men took on senior positions in nursing, they adopted expert status as managers and educationalists. In spite of a significantly lower educational achievement base than their female equivalents and their comparatively 'lower' class origins, ambitious men

were not at all dissadvantaged by their gender difference unless they were Black. In the following section, the disadvantage and discrimination faced by Black nurses at every stage in their nursing careers is discussed in some depth.



## **Part 4**

### **Racial divisions: the Black nurse**

In spite of the influx of men into general nursing and their subsequent career paths, it is arguable that the strongest challenge to the middle-class white feminine identity of the nurse came not from men, but from the steady flow of Black women into nursing from the mid 1940s on. At the end of the second world war, a crisis in nursing (man)power began which was to remain unalleviated until the mid 1970s, when the twin forces of economic restraint and unemployment effectively ended the situation. During this period, many matrons sought to alleviate their staffing shortages by making use of government policies which saw the training of nurses from the former British colonies as a form of 'overseas aid'. It is unknown exactly how many nursing recruits came to Britain in this way since no figures were kept by any government body, but by the time the U.K. Council for Overseas Student Affairs (hereafter UKCOSA) was set up as a charitable body in 1968 to co-ordinate overseas student interests, there were in excess of 17,000 nurses in training from countries outside Britain, a figure inclusive of students, pupils and pupil midwives. One of UKCOSA's first areas of publicly expressed concern was in relation to the position of these nursing 'students', whom they maintained were being used as cheap labour to prop up the NHS. Since the UKCOSA document is the first official publication to recognise this hidden minority as significant contributors to health care in Britain, their evidence to the Briggs Committee on Nursing is an important watershed in the documentation of race relations and the NHS. It can be summarised briefly as

follows:

- 1) Nurse training is often spoken of as overseas aid; most frequently it is the use of labour.
- 2) Selection of recruits is random and unco-ordinated, with little competent evaluation of qualifications. Assessment on arrival is often hasty which affects the morale of the student, the benefits of training, and efficiency of the hospitals.
- 3) Immigration regulations for nursing students are different from those of all other categories of overseas students. It is easier for them to come and easier for them to stay.
- 4) Very few receive any introduction or orientation to life in Britain. 'A girl may leave Mauritius on Monday and be on duty in a Manchester ward on Wednesday without having adequate spoken English or any elementary awareness of British life and customs'.
- 5) Overseas nurses are subjected to pressures a British nurse does not suffer, and these are accentuated by absence of orientation, grouping together in nurses homes, lack of facilities in homes, and the absence of advisors.
- 6) After training, qualified nurses are often encouraged to stay in Britain, explicitly by the training hospital, implicitly by the home office. The value of the training for the home country is therefore postponed or lost. This applies equally to government sponsored and privately sponsored students.
- 7) Most who return lack nursing skills relevant to their own country.
- 8) No comprehensive or accurate evidence, statistical or otherwise, on overseas nurses exists.

(UKCOSA 1971)

Until the publication of this report, issues of race and racism within the National Health Service had not been raised within the arena of public policy and debate. This is not to say that there had been silence on the issue until this point in time: papers like **Black Voice** had carried articles written by Black nurses on the day to day discriminatory practices and racist attitudes they constantly confronted in their work (UKCOSA 1971). However, it is only with the publication of the UKCOSA study as a contribution to the evidence placed before the Briggs Committee that there began to be any attention paid to these issues at the level of public policy. Given that by this time, Black labour formed 25 % of the nursing workforce overall, (Stones, 1972) and that Black nurses had played a significant role in alleviating the chronic staffing problems faced by the emergent NHS since its inception, the significant absence of their representation in all forms of discourse related to the nursing profession warrants investigation. This absence of representation goes beyond the mere fact that images of Black nurses were not used in brochures and booklets used for recruitment, although of course this did in long term affect the recruitment of British born Black people to nursing (Rose, personal communication, 1992; Torkington, 1985). What academic critics of theories of representation tended to ignore in their criticisms of content analysis is the fact that representations have a direct relationship to issues of power and control. It is not so much a question of whether the representations equate to the real conditions of life as experienced by the majority of Black nurses, but of the framework of imaginary concepts that shape and inform a sense of what the material reality of nursing might, could or should be for Black nurses. As long as nursing is presented as white, middle-class and feminine, those who do not fit this

ideal, even if they are twenty-five percent of the nursing workforce, are marginalised as outsiders, unlegitimised and lacking in status. If this figure is added to the eleven percent of male nurses, the total of nurses who are not white or female is thirty six percent, but still the dominant image of the nurse in both the public and the professional imagination continued to be one of white femininity. In this section of the chapter, I will try to suggest why this was the case, but before doing so the invisibility of Black nurses needs unveiling.

The history of Black nurses has remained, until recently, a submerged and largely invisible one, missing from even the 'new' histories of nursing written from the late 1970s on. This is partly because these new histories tend to have concentrated on the more distant past, but also because Black nurses have not made the kinds of in-roads into the nursing hierarchy that male nurses have achieved, remaining largely as rank and file members of the profession in the relatively low status areas of care such as geriatrics and psychiatry. This has implications both in terms of the status of Black women in the profession overall, and in relation to what becomes known about their situation. Absence from both the management and the professional sectors of the nursing hierarchy has resulted in virtual invisibility, since it is only at this level that research gets done, articles are published and policy debated.

As I pointed out earlier, the hospitals which tended to cater for the specialities in which Black nurses found themselves working were the former workhouses and asylums, hospitals that carry low prestige in medicine and therefore by association, also in nursing. These hospitals found it particularly difficult to recruit staff in the

changing labour market of 1950s and 1960s Britain. Prior to the second world war, many of these hospitals had relied on Irish immigrant labour to staff the wards, but as this pool of available labour began to shrink, matrons and administrative officers increasingly turned to what was euphemistically called the 'New Commonwealth' as a means of supplementing local recruitment. Overseas recruits tended therefore to enter the least prestigious areas of nursing and were heavily concentrated in those hospitals that had the most severe recruiting problems. Many of these hospitals were situated on the periphery of large urban conurbations, particularly the Greater London area. At one stage, one hospital in Essex had a nursing labour force consisting of in excess of 95% of people born overseas in countries ranging from Malaysia, to Mauritius and the Caribbean (Thompson 1974).

Since so many overseas nurses ended up working in the psychiatric sector, much of the writing about their situation tends to emanate from this field rather from general nursing. This is also the field of work where Black male trainees were situated. Statistics about overseas nurses were not systematically compiled until the early 1970s, so there is no way of knowing exactly how many overseas students came to Britain to train as nurses, where they trained, what qualifications they achieved, and whether they stayed in Britain or returned home. What is clear however is that most of these overseas students were Black and came from what was defined as the 'New Commonwealth' countries - Africa, and what was then known as Malaya and the West Indies. Many came expecting to train as state registered general nurses, the only qualification recognised in their home countries, and found themselves training for state enrollment, often in specialities such as psychiatry and mental subnormality -

- specialities which did not exist at home. These various kinds of training were not apparent to them when they applied to train, and do not seem to have been explained to them on their arrival or subsequently, resulting in many students achieving qualifications that would be of little use to them in their own countries (UKCOSA 1971). In addition, these applicants did not have any notion of the kinds of difficulties that they would be faced with because of the colour of their skin, a fact that most of the literature in this area tends to ignore.

The nursing profession, as I have pointed out, shared the same kind of assumptions about class as other institutions in British society. As a letter to the **Nursing Times** from a student nurse training at an Oxford teaching hospital in 1953 points out, for nursing to be a profession it is essential to have a status hierarchy, since all professions maintain their power through exclusivity. Within the status hierarchy of the nursing profession overall, as I have previously pointed out, state registered general nurses had become the most powerful professional group. Overseas Black nurses therefore started their careers with numerous disadvantages. Not only had they been recruited into the least prestigious and least powerful sectors of the nursing profession, but within this sector they tended to be trained for the roll rather than the register. The 25% of the nursing workforce who were black were heavily concentrated at the bottom of the status hierarchy, doing nursing work that could be described as the most physically demanding and the dirtiest, for the least financial reward. This 'co-incidence' of hard, dirty work and black skin, with low wages and various kinds of abuse is further examined in Chapter 3; at this point it is important to note how the historical divisions within the hospital system that were unresolved

by nationalisation worked to particularly disadvantage Black nurses. As the UKCOSA report points out, government policy which presented training for overseas nurses in Britain as a form of 'aid' to under developed countries was in fact little more than a means of supplying a labour force for the work that white Britons no longer wished to do. Neither the work experience or the qualifications were of use to students who wished to return home after training. It is therefore at the very least euphemistic to describe as 'aid' a practice which had grown in response to a national labour crisis.

The Royal College of Nursing's attitude to the problems of overseas students in the early 1970s in the light of UKCOSA's evidence to the Briggs Committee certainly acknowledges this problem, stating that many recruits came expecting to be learners and instead found that they were labourers. They also admitted that many students were channelled into state enrollment, but qualified their position by adding, 'Many of those accepted for training in this country would not meet their own national requirements for acceptance for training. It is believed that steps should be taken to ensure that nursing students from overseas are of a standard comparable to that required of students in this country and that they are reasonably proficient in English' (RCN 1971: para. 62). Although the evidence is sketchy, the facts seem to indicate that the RCN's assumptions are actually just that, statements made without sufficient research to support them. In a study of educational attainment of male overseas recruits, Stones points out that in terms of GCE qualifications at 'O' and 'A' level, overseas men were far superior to their British counterparts although 64% had been rejected from student training. They also had a comparatively higher success rate in

examinations for both the register and the roll (Stones, 1972).

The RCN also claimed in their evidence that one of the main factors in the problem of recruiting and retaining nursing staff was an 'undue reliance on overseas recruitment'. As Stones points out, the evidence shows that this was not the case. A GNC wastage study of the period 1957-59 had shown little difference between the wastage rates of student nurses from the UK, Ireland and the Commonwealth. In fact, 'In general and mental training schools Commonwealth students had consistently higher pass rates than students from other countries'. The results of Stones' own survey of male psychiatric recruits showed that male overseas students were more stable during training than their British counterparts, with British wastage rates higher in all types of hospital (Stones 1972: 141-144). It is therefore significant that the RCN is seeing overseas nurses as a 'problem', given the history of difficulties experienced by the profession in attracting their 'ideal type' of candidate and retaining these white, middle-class British women after qualification. Could it be that the RCN, unable to come to terms with the changing composition of the nursing workforce, saw increasing numbers of Black nurses as threatening to the profession's image and status?

In her review of the literature on recruitment and withdrawal from nurse training programmes published in 1969, MacGuire summarised over 60 research projects published since 1940 which have a direct bearing on the topic (MacGuire 1969). Few include any analysis of overseas students, partly because much of the research is conducted into training schools based in teaching hospitals attached to university



medical schools. As I have pointed out, overseas students rarely trained or worked in this area of general nursing, and therefore will be unrepresented in the research relative to their numbers overall. However, Bannister and Presley's 'Test Selection of Overseas Nursing Candidates: A Cross Validation Study' (Bulletin of British Psychological Society, July 1967) concluded that neither the Progressive Matrices Test or the GNC overseas test 'provided an adequate basis for the selection of overseas candidates' (MacGuire 1969: 134). This supported earlier reservations expressed by Crookes and French (1961) on the 'suitability of using the Progressive Matrice Test with West Indian students' (ibid: 166). Knight's study on recruitment and wastage of staff amongst 7435 student and pupil nurses recruited into hospitals in the South East Metropolitan Region between 1961 and 1965 found that students from Eire and overseas had the lowest discontinuation rates (ibid:178). These studies not only point to the lower attrition levels amongst overseas nurses, but also question the validity of the testing methods that placed so many of them in pupil nurse training programmes.

In the only study of Black nurses in MacGuire's literature survey, Martin investigated 'West Indian Pupil Nurses and their Problems in Training' (1965), interviewing 46 nurses at a metropolitan geriatric hospital and following up the careers of 95 nurses admitted to the roll in 1958-64. Four-fifths had left the hospital in the first twelve months after enrollment, and few had stayed longer than twelve months. The reasons for this are described as 'attitudinal aggression' through being cast in the role of 'stranger' and the 'unrealistically high expectations' expressed by interviewees who were mostly leaving to become 'proper' nurses through undertaking SRN training

(ibid: 186). Another researcher could interpret these results quite differently, pointing out that groups of people, faced with very different situations to those that they had imagined (or were led to believe?), found sufficient strength and solidarity to maintain their self esteem and to try and improve their situation! This study, like many of the studies of attrition of the period discussed in part two of this chapter, tends to emphasise personal characteristics as the principal cause of the problem, rather than looking for institutional reasons.

It does seem then that the RCN's assumptions about the instability of overseas nurses are not born out in the research summarised by MacGuire for the Department of Health and Social Security, or in subsequent studies. Even in Martin's study (above), the enrolled nurses were hardly lost to the profession if they were aiming to train for registration. The question must be asked how the RCN reached the conclusions that they did, and why the Briggs Committee, in their final recommendations, reached quite different conclusions. Before any attempt is made to do that however, it is necessary to chart what is now known publicly about Black nurses experiences of recruitment and training, although there are still many gaps on the map. In recent years, attempts have been made to fill in some of the gaps with evidence from oral histories, and it is largely from these that the following summary is compiled.

**In The Heart of the Race: Black Women's Lives in Britain**, Bryan, Dadzie and Scafe have recorded interviews with Caribbean women from all walks of life who found themselves, for one reason or another, in Britain from the early 1950s on. They say that in the Caribbean, nursing was (and still is) a highly-rated profession,

‘respected enough to attract Black women already in work to give up their jobs, and come to Britain to train as nurses’ (1985: 38). The promise of a better life in England, ‘the way they made it sound in the recruitment adverts and broadcasts’, (ibid: 24) created a horizon of expectation for many people that was doomed to disappointment. The weather, the cities, food, housing conditions and the unfriendly, racist attitudes of the native population hardly matched the promise of a better life, but once here, few had the resources to leave. Many had to send a proportion of the training allowance home to support relatives and repay the money borrowed to the pay the fare. Many trainees, expecting to be students, found themselves on pupil courses with no choice in the matter and no opportunity, because of financial limitations and immigration restrictions, of trying another training institution. Others found themselves as auxiliaries or ward maids, unable to train either because their qualifications were in question, they had failed the GNC test or their English was considered inadequate. Because of their financial situation, many could not afford to leave and had to remain, no matter how unhappy they were. Lee (1976) found as many 42.6% of his sample fell into this category (quoted in Baxter 1988).

There was no uniformity in the processes of recruitment and selection of candidates. Some trainees wrote to hospitals directly in response to adverts placed in the local paper, or were recruited by hospital representatives (usually the matron) visiting their home town/country. Others wrote to hospitals where friends were already training, or used agencies, which made all the arrangements at inflated prices. Applications could also be made through the government offices of the home country, who vetted applications and passed them on via the consulate to a British hospital. Others

entered Britain on other terms (often as the wife of a student visa holder) and then applied for training. GNC guidelines were used for vetting locally obtained qualifications, which included an English language qualification as part of the minimum requirement, but very few attempts were made to test spoken English before a candidate left her own country. The student, arriving with the expectation of studying for state registration, could find herself placed as an auxiliary or a pupil nurse because her qualifications or her spoken English were judged to be inadequate, and she had failed the GNC test. By this time, she rarely had a choice, she had to accept both the decision and the situation she found herself in.

In 1988, Training in Health and Race produced a campaigning document which sets out the case for equal opportunities in nursing. Their survey of the literature points out how most of the studies conducted between 1970 and 1980 on overseas trainees place the emphasis on cultural differences when trying to explain the problems experienced by Black nurses (Baxter 1988: 18). Baxter points out that it is only in the work of Hicks (1982) that racism emerges as the principle cause of disadvantage and frustration experienced by Black nurses, but even here 'there is no analysis of how racism is mediated by the complexities of organisational control, power and social relations' (ibid: 22).

Given the paucity of information available on the experience of Black nurses, Baxter and her colleagues undertook a series of case studies which aimed to make the history of Black nurses and their experiences of racism within the NHS more visible. The results are sobering, and indicate something of the personal trauma experienced by

many overseas trainees when they arrived in Britain. In addition, Baxter's study reveals the problems experienced by British born Black recruits, some of whom were channelled into SEN training even though they had passed the GNC test. Many found it impossible to transfer to SRN training even after they had become state enrolled. Some nurses clearly felt that it was the prejudices and attitudes of some of their managers that was their biggest obstacle, and that this prejudice existed as much amongst the teaching staff as it did amongst those in administration. (For a confirmation of this view, see Chapter 3).

Partly as a result of their parents experience, many young Black school leavers, particularly those with Afro-Caribbean backgrounds, have internalised an 'SEN' image of themselves as a 'protection' against the possible indignities of SRN rejection (Baxter 1988: 27-29). Rose's experiences of recruiting trainees in Liverpool in the 1970s certainly supports this:

'Principal (Divisional) Nursing Officers were not in favour of having "too many black faces" on the wards - albeit they would rarely admit to it. On the other (hand) as I discovered when talking to school pupils or at careers conventions, the local black pupils had a self-denigrating attitude, in that they did not believe they were "clever enough", or worse still, that being black they would never be accepted for training at a Liverpool hospital' (Rose 1992).

According to Baxter, Asian girls are often discouraged from pursuing nursing as a career by career guidance at school, ostensibly because of the uniform restrictions, whereas well-qualified British born Afro-Caribbean women still have to combat the

stereotypical view that nursing is the most suitable career for them (1988: 29).

Baxter's study goes on to point out the discriminations faced by Black nurses at every stage of their careers. Not only did they have more difficulty in being accepted for SRN training, but they then went on to face poor promotion prospects, even though often acting in senior posts. Those that do find their way into management are often faced with a lack of co-operation from white staff and have to work twice as hard to prove themselves. 'A survey of six health authorities in 1983 revealed that there were no Black district nursing officers, only two out of the directors of nursing services were Black, as were only seven senior nurses (Baxter, summarising Agbolebe's paper 'Fighting the Racist Disease', 1988: 16). Often, Black female managers have to face the double disadvantages of racism and sexism, in a working environment that has become increasingly dominated by male managers as the previous section of this chapter discussed.

Many of the nurses Baxter interviewed felt considerable pressure to conform to a white image of nursing. This was felt most acutely in relation to management's comments on hairstyle and body image. In recent years, assertion of cultural identity through hairstyle, such as wearing plaits, has met with considerable opposition even though hair is worn away from the face and off the shoulders, in line with hospital regulations. To quote one of Baxter's interviewees,

'Nursing bosses continually make remarks about the unsuitability of a black nurses' physique for the various uniforms that are worn. Throughout a nurse's training, it is stressed that one's appearance is just as important as a skill.

Not just any appearance but the one that is acceptable on the ward - that of a 24 year old white nurse' (1988: 56).

This last comment clearly shows how the image of nursing is not just a matter of the content of representation. The image of itself that the nursing profession has presented and promoted is an ideological construct of white femininity that deeply pervades all levels of the profession, and is as much a material practice as a framework of ideas, beliefs and attitudes. In trying to assess which factors have contributed to sustaining that practice in the years 1950-75, some conclusions can be drawn. Before I do that however, it is necessary to examine the conclusions that the Briggs Committee on Nursing reached, since this was the first government body with a specific brief to analyse and comment on the image of nursing.

## **Part 5**

### **Briggs and the image of nursing.**

By the late 1960s, the recruitment problem had not only continued unabated but increased in intensity, along with a growing dissatisfaction throughout all sectors of nursing with levels of pay and working conditions. Nurses' pay by this time had fallen so far behind that of other workers that in some cases hospital domestic and cleaning staff were earning more than the lower grades of nursing staff. The RCN, faced with increasing pressure from members broke with their anti-union, anti political action stance, and instigated a major programme of protest now known in nursing history as 'the raise the roof campaign'. Following this campaign, a Royal Commission was set up by the then Labour government to: 'review the role of the nurse and midwife in hospital and the community and the education and training needed for that role, so that the best use is made of available manpower to meet the needs of an integrated health service' (Briggs 1972).

By 1974 however, the gains achieved by the 22% pay rise of 1970 had been whittled away by inflation and there was further unrest, this time much more militant in character. Nurses' wages had fallen below those of other skilled female workers like shorthand typists and primary school teachers. For the first time, nurses walked off the wards, demonstrated and marched, and worked to rule. Clearly, consensus within the profession had broken down. Many young nurses, faced with the realities of modern hospital life, joined demonstrations and protests, renewing their demands for



a decent wage and an end to split shift duties and twelve hour days. Pictures of dissenting nurses marching in protest wearing their nurses' uniforms clearly caused disquiet amongst both managers and professionals, and are largely absent from modern histories of nursing. Baly, for example, in **Nursing and Social Change** dismisses the events as part of a climate of national discontent even though the action secured the largest pay rise of the post war years and finally gave nurses a degree of parity with other female workers (Baly, 1980).

The post-war image of nursing, as proclaimed in 1950s recruitment literature, was one of service and authority. In **Your Chance** (1950), as I pointed out earlier, the ambitious working-class girl is interpellated by a potentially familiar popular image associated with adventure and excitement. The brochure promises not only a job, but 'a career with status and prospects', an opportunity to change her social status through service. This image conveys the strength of the managers in recruiting policy at this time, and the growing commitment amongst senior nursing staff to recruit enough nurses to staff the newly formed health service. Its counterpart is the material produced by the Nursing Recruitment Service, which is addressed specifically to a middle-class, grammar school readership. Rather than service, it promises authority and professional autonomy.

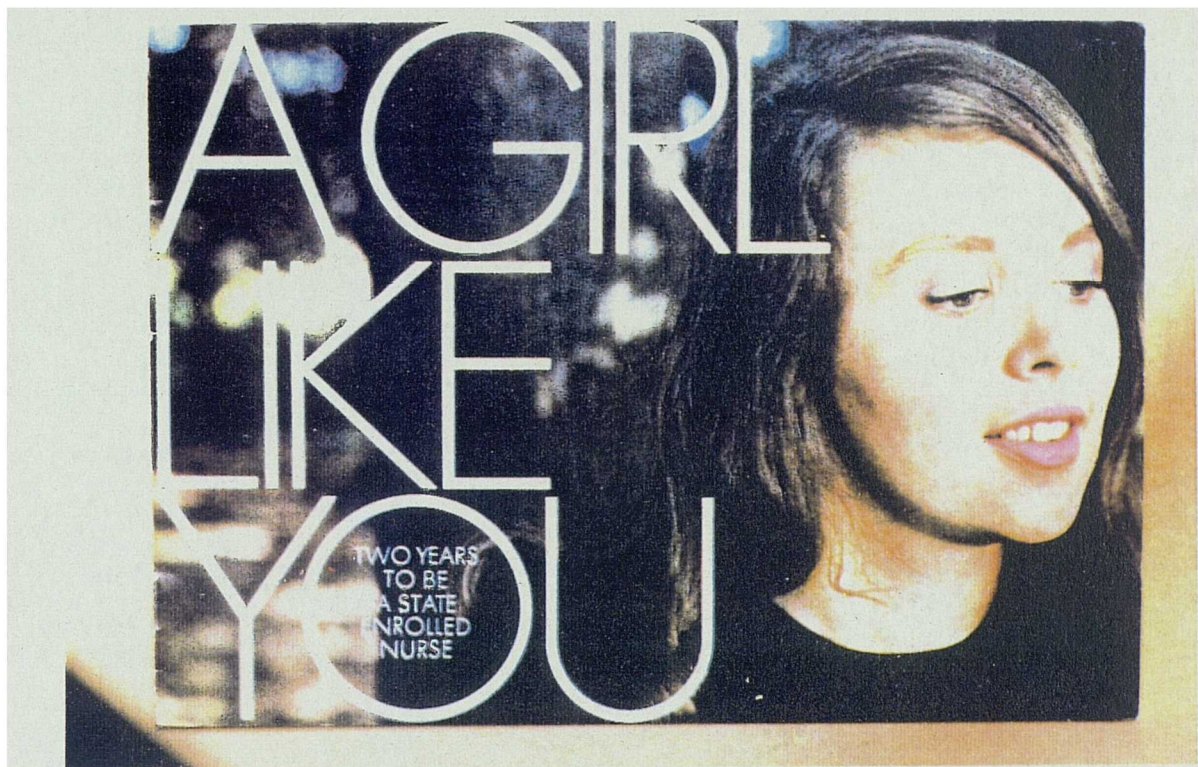
By the late 1960s, these two polarities are no longer represented in quite the same way. The literature has become clearly divided into training for registration and training for enrollment. The former tends to emphasise the high tech drama of modern medicine in brochures like **SRN** (1965), with its dramatic use of black and

white documentary style photography; the latter tends to play on popular fantasies of femininity and nursing, such as physical attractiveness, romance and maternal care. Documentary realism is used to interpellate the professionally inclined (middle-class) reader, whilst discourses of service embedded in a sub-text of romance and motherhood are used to attract practical (working-class) girls. Leaflets, on the other hand, tried to appeal to young women across the board, with the result that a variety of approaches were tried, from the innocently inviting appeal of **Nursing** (1966), to the comic cartoon style of **Want to be a Nurse** (1970), with its play on fashionable hair cuts and large eyes, popularly known at the time as the 'Biba' look.

The recruitment crisis motivated a campaign to persuade trained married nurses to return to work, and older women to take up training for the first time. Much of the appeal to older women was conducted through the pages of popular women's magazines like **Woman** and **Woman's Own**. In **Too Old to Train for Nursing?** (1969), the letter format of personal testimony is used as a way of persuading women that training in later life can be both personally and financially rewarding. **Like to Be Back in Nursing?** (Leaflet NL 027, 1972) uses the 'makeover' approach common in many women's magazines of the time, where a new make-up regime and a hairdo are seen as the solution to lack of confidence and a poor self image. This form of masquerade is used in nursing recruitment to emphasise how a return to nursing can be re-vitalising, creating a new (youthful) lease of life. Soft focus photography and yellow filters are used to accentuate the impression of longing and depression in the picture of the woman on the front of the brochure, whilst over the page, the harder lighting makes the contrasting colours of hair and make-up stand out clearly against

the whiteness of the uniform. The sub-text is of course the re-invigoration of the redundant mother, an association made more clearly explicit in the 1973 brochure **You'd make a good nurse**, which pictures a woman talking to an older child on its cover.

By the early 1970s, nursing recruitment for state enrollment had become deeply enmeshed in fictioning a specifically feminine nursing identity. In **A Girl Like You** (1970), there are clear references in the address of the title to the words of a popular song ('It takes a girl like you to make a dream come true') and in the imagery to contemporary advertisements for cheap make-up. (The picture calls to mind in particular the advertising used to sell the popular brand Outdoor Girl, which was available in Woolworths at the time.) Like its predecessor **Proud Badge of Service** (1966), this brochure emphasises how unexceptional 'Philomena' is. The use of an unusual Irish name however undercuts the 'ordinariness' of the brochure's address. Like its forerunner of the 1950s, it is again appealing to those who are upwardly aspiring, but in this case good looks and attractiveness (heightened by soft focus photography and low contrast, creating feminine softness) are foregrounded against the harsher black and white documentary 'realities of modern hospital life'. The SRN and SEN brochures of the mid 60s have become fused in this 1970s SEN edition. Instead of a sub-text of marriage as in the previous SEN brochure however, a sub-text of romance promises a fun social life and a doctor boyfriend with a sports car, whilst the drama of working life emphasises the high-tech of the operating theatre. The melodrama of life and death struggle becomes the *mise en scene* for fun and romance, echoing the narrative strategies and realism of hospital documentaries, soap and the



*Plate 19: 'A Girl Like You'.*

more exotic locations of doctor/nurse romances.

By the early 1970s, fiction and reality have apparently fused. The image of nursing promoted by the profession is also the image of the nurse found in many popular fictional narratives. It is my contention that the gradual assimilation of one discourse with the other was a result of the desire to create an imagined homogenous community of nurses. The gradual disappearance of images of authority in anything other than teaching roles, whilst perhaps creating a more friendly picture of hospital work, also lowered the threshold of expectation of those coming into nursing, since individuals were only interpellated as trainees, never as qualified nurses in positions of responsibility. The future, as a qualified nurse, became a distant reality compared to the sense of drama and immediacy created by documentary style photography and the possibilities of fun and romance. The romantic, angelic image of nursing reaches its zenith in *A Girl Like You*, but is contradicted publicly by media images of anger and dissatisfaction. This contradiction was of interest to the Briggs Committee, and I shall return to it later. At this point, I want to turn to examine public attitudes towards nurses during this period. How did the public perceive nursing's image of romantic devotion? And why were young men more inclined to see nurses as 'easy lays' and 'quick flings' rather than dedicated wives and mothers?

The public perception of the nurse as an image of angelic asexualised feminine values of service and self-sacrifice began to be questioned at this time. Nursing had advocated and used this image to advance its claims to a 'separate but equal' professional sphere to that of medicine, and to bolster its own claims of authority.

But in a public service economy where nursing was regarded as a right rather than a gift or a privilege, there was a growing dislike of the ideology of white female middle-class 'maternalism' that the image of the angel represented. This failure of the image's authority became increasingly visible in the softporn images of many 1960s films, the public face of an underlying misogynistic dislike that could be found in the hidden hard core pornographic use of nursing imagery. It is difficult to separate the nexus of strands contributing to this increasingly public presentation of the nurse not as an 'angel', but as a whore. It is an over-simplification to explain this imagery in terms of its historical precedent, the 'Sarey Gamp' drunken sick attendant of Dicken's mid-nineteenth century novel **Martin Chuzzlewit**. Dicken's picture is of an older woman, not a young and attractive one. The modern manifestation of 'nurse as whore' is a result of fantasies about the specific relations between nurses and nurses, doctors and nurses, and patients and nurses. Some aspects of this triad are necessarily pointed out here, since at this particular point in time the image of nursing becomes the site for determining policy under the leadership of a government committee chaired by the media and broadcasting historian Asa Briggs.

The Briggs Committee was set up in 1970 'to relieve the (Labour) government's embarrassment over the threat posed by nurses to its prices and incomes policy' (Dingwall *et al.* 1988: 205). This situation is seen by Dingwall as typical of the Labour government of the time which used Commissions and Departmental Committees to deflect immediate political problems. Rather than quantifying or assessing the effects of any changes that may have been needed for reform, Briggs had to work within the existing manpower and budgetary constraints. This meant that



managerial interests were able to absent themselves from participation 'by playing the "resource implications" card', leaving the field clear for the nurse professionalisers who had a strong base in the RCN.

Dingwall is somewhat dismissive of the report because of its lack of attention to economic and structural reform, but nursing commentators like Baly see the situation as a triumph of professional nursing and the RCN (Baly 1980: 322). Baly also has a very positive view of the processes created by RCN for presenting evidence to the committee, because in her view, 'The evidence given by the Royal College of Nursing and contributed to by so many people is worth recalling in order to stress that the impetus for a new philosophy and the need for unified government of the profession came from nurses themselves' (ibid). Perhaps it should be pointed out that this a professionalisers view of the situation rather than a managerialist one. Baly's scant attention to the militant campaigns of 1974 that followed the Briggs report underlines her position, for rather than looking at nursing's unresolved internal tensions, she places the more militant campaign amongst a general culture of unrest that swept through Britain at the time.

It is, then, the professionalisers view of the image of the nurse which is reflected in the Report of the Committee on Nursing, published in 1972. The Briggs Committee devoted a surprising amount of space to the public perception of nursing, examining those aspects of the image of modern nursing which seemed to have been historically determined. These were identified and summarised as:

a) the doctor's handmaiden

- b) nurses' fight for their professional status
- c) the class aspect of the vocational ideal
- d) an authoritarian hierarchy created by 'the search for perfection and the attempt to achieve it by discipline'.

Note that any possible references to issues of sexuality, race or gender are omitted through this historical approach, and are not broached by the committee.

Briggs saw these four identified images and ideals as reinforced by mass communications, which look backwards to Victorian Britain and its values as well as forward to an age of integration. Amongst the most influential mass media images, Briggs singled out books and mass circulation magazines, television series, films and newspapers. Briggs was convinced that these images influenced recruitment and 'predetermine attitudes at critical moments in the health history of individuals and families'. There is no mention in the report of pornographic representation, or of the increasing numbers of popular films which in some way questioned or mocked the traditional nursing image.

In an examination of the existent recruitment literature, Briggs commented on the variety of jobs in nursing and midwifery, the emphasis on teamwork rather than individual vocation, and the personalisation of the brochures, dealing with different career profiles and different career aspirations within the profession. He saw this as a recognition by the nursing establishment that things were changing. The emphasis in recruitment literature by this time was on the need to care for others in an increasingly complex society; nursing was 'something special' and inwardly



rewarding.

The brochure **Something Special**, brought out in 1972, uses a 'take four girls' approach, following the training and careers of four women from very different backgrounds with a range of ages. Significantly, the women are still all white, and there are no equivalent profiles for men, but the separate brochures for training for the register and training for the roll have been combined, and there is an associated emphasis on teamwork.

Briggs sought the opinion of new recruits to see if there was a gap between the image being portrayed in recruitment literature and their experiences of training. Answers to the questionnaires suggested that dissatisfaction with work, hours and shifts was less prevalent than expected, but that nonetheless there was a significant amount of complaint about the drudgery of non-nursing duties and the attitudes and behaviour of nurses themselves. Briggs' concluding comment in this part of the report is a salutary one, and it is worth quoting in full since it does point to one of the main themes of this thesis, that women oppress other women for reasons of power and status: After examining together all the criticisms and hopes of improvement, we wish

'to stress that unless sympathetic care within nursing and midwifery administration is shown to nurses and midwives both in training and after they are trained, the wider claims of the profession to rest on individual care will ring hollow. Care starts with the relations between nurses and nurses. So to does sympathetic understanding on which all care is based' (Command 5115: 38).

## **Endnote**

Clearly, there was an increasing strain on nursing's image of idealised femininity throughout the post-war period, but this strain cannot be wholly attributed to the changing image of women in contemporary society, as one leader of the profession claimed at an international conference in 1977. Other, more specific factors were clearly at work, which have more to do with the nature and substance of modern health care and the patterns of expectation it had created in society than the position of women per se. It is the position of women within the division of labour in health care that has to be examined, since women form the majority of the health service labour force and are situated at the interface between sick individuals and all forms of medical services.

Public perceptions and expectations of health care and nurses were increasingly informed throughout this time not only by the mass media, but through direct and continuing contact with local health care services. They were also informed by an emerging discourse of consumerism, coming from the Left and more generally, which placed consumption rather than production as a contested sphere of oppression (Karpf, 1988). Whereas in the immediate post war period modern medicine and the welfare state had appeared as a universal panacea, the solution to both individual ills and a sick society, twenty years later considerable doubts were beginning to take root about the efficacy of many treatments. Many of these doubts focused on issues of medical power, which began to be severely criticised by feminists in the emergent women's

health movement (Boston Women's Health Collective, 1971), anti-psychiatrists like Laing and Szasz (1973) and the Jesuit intellectual Ivan Illich (1976). All in their different ways pointed to the iatrogenic nature of much modern illness - modern drug therapy and new surgical techniques were creating as much illness as they were curing. The post war awe of modern medical science was beginning to break down; this became apparent in consumer discontent with modern medical practices, which began to manifest itself in the creation of self-help and consumer pressure groups and a renewed interest in various forms of alternative medicine and healing.

By the late 1960s, a whole generation of young people had grown up under the paternal wings of the welfare state, and a whole generation of older people had died within its care. The vast majority of the population had become familiar with NHS services through having to use them at some time in their lives, and many had to face the contradiction that the miracles of modern western medicine portrayed in the press and on television could do little to cure them of their ills or even alleviate their discomforts. Whilst open heart surgery and transplant operations were clearly possible, the availability of this kind of medical intervention was severely restricted. At best, the service was able to cure some kinds of illness and alleviate the pain and suffering caused by others, but at worst it could be found wanting on all these fronts. High quality medical and nursing care still depended on money, as it had always done, with social status, race, gender, age and the important additional factor of geographic location all affecting an individual's accessibility to services. The great rhetorical flourishes of the post war re-constructionalists had created the concept of 'care from the cradle to the grave', but achieving this ideal was clearly proving to be

another matter. Old Victorian buildings, overworked and underpaid staff and restrictive regimes of care based on task centred nursing practices could turn the hospital experience into a harrowing rather than healing process. For many elderly patients, the hospital in its new guise was little more than the old workhouse or Poor Law hospital in modern form, and they feared it accordingly.

One way of summing up the changes in health care management in the post war period is to describe the effects of nationalisation as an increasing use of Fordist organisation strategies. The task-centred structuralist approach to patient care favoured by nursing managers clearly falls into a managerialist ethos of industrial production, where getting through the work and moving patients through the system are the primary objectives in productivity terms. The cure and care of the patient, in this process, is seen as analogous to the assembly of a car on a production line, conveyed through a system of tests and treatments until deemed cured or placed on the scrap heap of permanent care. As Williams points out (1978), during the mobile part of the process the patient is likely to be attended by a 'professional' nurse, someone whose imagery tends to be based in clinical concepts and medical conditions; this person performs technical bedside tasks such as maintaining hydration, or preventing circulatory collapse through the administration of drugs. Once the patient passes from the 'cure' to 'care' category however, she or he also leaves the care of the 'professional' nurse to be attended to by others - auxiliaries, students and nurses aids. The sick individual who is still helpless becomes just another helpless adult who has to be toileted, fed and kept clean. Since their medical condition no longer dictates the regime of care, physical functions formerly defined in medical terms

become redefined in everyday language and forced to fit within the general pattern of ward routine. The overall system of care depends upon the fact that certain tasks defined as skilled are undertaken by one group, who then pass the patient on to another group once s/he is no longer defined as being in a clinically critical state, since that person is no longer deemed in need of skilled attention (Williams 1978).

The servicing of the patients' physical condition by medical and nursing staff can however bear little relation to the patients' directly felt and experienced needs, which become subjected to hospital routine and discipline. This subjugation creates its own patterns of resistance, particularly amongst male patients who are accustomed to their demands being met by women - and the nursing workforce at this time, even on male wards, was still overwhelmingly female, particularly in the lower staffing grades where most interaction with patients occurs. Women, dressed in uniforms reminiscent of the position of their forebears as domestic servants, engage in intimate bodily contact with patients of both sexes to meet their physical needs. The task centred approach to care programmes these needs into the ward routine, and transforms the meeting of need into an exercise of power and control. A good example of the type of incident that can occur is bedwetting by a patient who is unable to control their bladder until the 'bedpan round'. Such patients are likely to be treated as regressing to childlike behaviour because they are unable to control their bodily functions. Task centred nursing actively prevents close communication between particular nurses and patients. 'Stop wasting time talking to patients and go and clean the sluice' was a common refrain echoed on the wards throughout this

period.

In the task orientated model of care, the relationship between the carer and the cared for clearly has power implications and can easily become a model for hierarchical authoritarian control. Those at the bottom of the status hierarchy who have to do the 'dirty work' of nursing are most likely to assert this control, interpreting helplessness in adults as a regression to infant behaviour, and treating the patient accordingly (Williams 1978). The sick individual is therefore torn between their need for ministrations and their frustration at not having those needs met. The promise in the smiling supplicancy of nursing promotional literature proves to be a double-sided one - a promise of tender, loving care, but also a promise of detached aloofness, of a surface value of caring which is experienced by the patient in an equally contradictory manner, with emotions that range from relief and gratitude, to those of fear, loneliness, and sometimes pain, panic, rage and sheer dread.

Within this context, the virtual absence of representation of the female patient from both the popular and professional images of nursing is noteworthy. Nightingale's nursing reforms initially conceptualised the patient as a brutish, lower-class male; arguably, she used a discourse of class difference in opposition to dominant medical and patriarchal discourses of gender difference to support her claims for nursing as an autonomous female profession. In the period after the second world war period however, the longer life expectancy of women placed the elderly female patient in the forefront of those most likely to need custodial care; accordingly, it was female patients who were most likely to be subjected to the kind of nursing provision

analysed by Williams (1978). In general nursing at this time, high profile surgical intervention tended to focus on medical problems experienced by males, such as heart disease, industrial illnesses and injuries. Female maladies (and gynaecological disorders in particular) were by definition of lower medical import, since they were conceived as inevitable processes of female biological destiny rather than as consequences of physical malfunction or external disease generating factors (see, for instance, Ehrenreich and English 1976). The invisibility of the lower-class female patient in the traditional discourses of nursing and the medical emphasis on cure rather care partially accounts for the absence of the female patient in both popular and professional representations throughout this period. Female patients are of course represented in the recruitment literature for midwifery, but in general nursing they are usually only depicted in the context of geriatric nursing as the 'frail elderly'.

To sum up at this point, at the level of institutional management the application of Fordist ideologies and structures appeared to be an efficient, economical solution to the problems of caring for large numbers of helpless people. This system also suited the aspirations of those who wanted to create a 'separate but equal' nursing profession, where the highly skilled were valued for their expertise and able therefore to maintain a position at the top of a status hierarchy of carers. This position ensured that the dirty work of nursing was always done by others, never by them. The professionalising project was dependent upon recruiting young, white middle-class women who would share the aspirations of professionalism with their peer group; those who wanted to become educated 'ladies' who were experts in their chosen fields (Pomeranz 1973). This status is, in part, a protection against doing the 'dirty work',

as some of the interviewees in the following chapter confirm. The student nurse protests of 1969 demanded that trainee nurses should be granted full student status, arguing that nurses were entitled to parity with other trainee professional groups. Full student status would of course prevent trainee nurses from having to do 'dirty work' on the wards, leaving them free to develop 'skills'. By 1974 however, demands for better pay and conditions led by the principle nursing unions, COHSE and NUPE led to universal calls to work to rule; the Royal College of Nursing, recognising the threat from 'the generalists' in the former munuciple sector, supported the call, afraid of losing its control at the centre of nursing politics and policy formation.

Lurking behind nursing's painted smile of the 1970s was a troubled picture of discontent. The problems caused by falling recruitment were resolved by the external factor of mass unemployment rather than internal resolution. By 1975, schools of nursing were full for the first time since the formation of the NHS, but the problems were to re-surface in the 1980s since they remained unresolved. A less romanticised view of nursing began to pervade the public perception of nursing which changes in the management of patient care and subsequent recruitment imagery has been unable to dispel.

In the third chapter of the thesis, the public and professional images of nursing analysed in these first two chapters are used as a starting point in discussions of nursing identity with women who became nurses between 1950 and 1975. The literature on images of nurses pays scant attention to the ways in which women who



are nurses think about themselves professionally. The issue of self-conception is explored here from several angles, using autobiographical writings and case studies. What emerges is a considerably more complex image of nursing identity than that which has emerged so far, but given the disparity of viewpoints solicited, a surprising degree of consensus emerges about what might constitute an ideal image, a 'proper nurse'.

## CHAPTER 3

### Introduction

*'The self as an image and images of the self can comment on the conjuncture of discourses and everyday commonplaces'.*

(Probyn 1993: 106)

Autobiographical writings and case studies are used in this chapter to explore the relationship between the self as an image and the various discourses of representation used to image that self. Personal accounts of nursing lives are figured against the ground of public and professional discourses discussed in chapters one and two. The methodological issues raised by this approach are discussed in the first part of this chapter, Nursing Identities and Conceptions of the Self.

The four successive sections broadly follow the chronological order of earlier chapters, starting with war-time and post-war experiences of training and tracking these as far as the mid 1970s. In each of these sections, recurrent themes and trajectories traced in earlier chapters are mapped against the individual accounts used here: in part two, autobiographies and personal testimonies are used to prise open the dominant stereotype of the figure of the nurse as an 'angel' in the post-war period; in part three the public image of the nurse as 'doctor's handmaiden' is dissected and mapped against the body of another of nursing's stereotypes, the 'battleaxe'. Part

four emphasises the experience of Black women becoming nurses in a white female hierarchical structure; and the chapter is concluded with a consideration of the discourses that have shaped each individual's concept of the 'proper nurse'.

## **Part 1**

### **Nursing Identities and conceptions of the 'self'.**

From the research into public attitude cited in Chapter 1, it emerges that certain groups in the 1960s seemed to hold one view of the nursing profession rather than another. For example, women tended to divide on class lines as to whether they thought nursing a suitable occupation for young women leaving school, with middle-class women tending to see nursing as a job involving hard work and drudgery, and working-class women seeing it as a vocational or professional role worth aspiring towards (MacGuire 1969: 150). On the whole, men were not keen for their female relatives to become nurses, stating preferences for secretarial work and teaching. Whether this was because they disliked the idea of their nearest and dearest engaging in the dirty work of nursing, or were aware of the pornographic imagination's use of nursing imagery is difficult to assess. Overall, the male attitude conveyed in the research of the time and recalled by some of the interviewees in the case studies tends to be presented as somewhat equivocal, suggesting that men who were fathers were certainly aware that nursing training could negatively influence the attitudes of other males towards their daughters.

Research into recruitment and attrition during this period did pay some attention to the actual processes through which young women (it was mostly young women) became nurses. Several of the studies collected by MacGuire (1969) point out that the image of nursing held by a girl was the most important factor in her self-assessed

suitability for training (Marsh and Willcocks [1965] in MacGuire 1969: 145, National Opinion Polls Ltd. [1966] in MacGuire 1969: 151). There is no mention however of what image that might have been, or how girls conceived of nurses and nursing during this period. The assumption tended to be that teenage girls who embraced the romantic notion of serving suffering humanity were those most likely to become nurses. This view was confirmed in a telephone interview with Miss H., a retired Sister Tutor who was in charge of nursing recruitment at Liverpool Royal Infirmary throughout much of this period. In these former voluntary hospitals, with their traditional connections to religious and charitable institutions, ideals of nursing as a vocation continued to be imbued into young trainees. On the strength of the case studies presented here however, I will argue that it is highly questionable whether all potential trainees saw themselves (or their new profession) in quite such a romantic or vocational light.

The issue of self-conception and suitability for training is explored in two ways in this study in an attempt to examine popular constructions of self identity and throw some light onto the question of why some women chose nursing as a job or a career during this period. This two-pronged approach relies on the one hand on written narratives in the form of autobiographical novels, and on the other on oral narratives prompted from memory in the form of case study interviews. Both forms have certain methodological problems which will be discussed below. Used in juxtaposition, however, these shortcomings become complimentary since they highlight the theoretical problems inherent in any attempt to use forms of narrative as the basis for knowledge about lived experience.

Feminist scholarship has made the relationship between experience and knowledge one of its primary concerns. Getting to know about other women's lives and trying to find ways to re-present those lives within official discourses and debates is a major feminist political task. Interesting parallels can be drawn between the struggles of feminist scholars and their attempts to legitimate women as subjects of their own discourse and nursing leaders who have struggled to make nursing an autonomous profession. Both have sought to authenticate their status through intellectual validation and academic credibility, the former through forging Women's Studies as an autonomous discipline in the academy, the latter through the application of medico-scientific criteria to nursing practice. Both have increasingly relied on theory to support their practice, and both as a result run the risk in their teaching and professional organisation of perpetuating hierarchical divisions and differences between women.

Nurses have rarely been credited with the authorial ability to write and represent themselves, but as I pointed out in the section on medical romance fictions, many of the novels in this genre are written by women who trained as nurses. Nurses have also generated a considerable body of writing that deals with professional issues, primarily in the form of textbooks and histories of nursing, but more recently in the form of scientific research monographs and articles. Traditionally, nursing was always seen as both a science and an art, and this was heralded as a strength of the profession. In recent years, professional nursing has tended to adopt theoretical approaches to care based on abstract models. According to some critics, these models have tended to generate a deficient view of nursing practice that only allows

the gaps to show (Benner and Tanner 1987, Benner and Wrubel 1988, Lawler 1991). Stories, narratives and case studies are increasingly being seen as a way of understanding nursing practice because they highlight the relationship between theory and practice and open up the thinking and beliefs that underscore much of nursing work. An approach to theory that is grounded in the discourse of practice can be seen as a re-valuation of what it means to practice the art of nursing, giving precedence to skilled practitioners and their experiences rather than abstract ideas and concepts. (For a fuller discussion of this point, see Lawler 1991.) To quote Derbyshire, who is pioneering this approach in the British context, 'We have a rich vocabulary which describes our deficiencies and our shortcomings, yet we have scarcely begun to develop a meaningful dialogue which reveals nurses' creativity and expertise in caring' (1991: 27). Stories and case studies written by nurses are increasingly being used in the creation of that meaningful dialogue.

In terms of feminist scholarship, stories, narratives and case studies can challenge official discourses and interpretations of women's lives. These methods of study, as the Personal Narratives Group point out, are especially useful for illuminating several aspects of gender relations: 'the construction of gendered self-identity; the relationship between the individual and society in the creation and perpetuation of gender norms; and the dynamics of power relations between women and men' (The Personal Narratives Group 1989: 5). I would add that these narratives can also illustrate and illuminate our understandings of power relationships between women, particularly those of race and class. Because they attempt to place the lived experiences of women within discrete theoretical models rather than trying to settle more universalising

arguments about the location of the self, the approaches adopted by the Personal Narratives Group have been particularly useful in shaping this section of the thesis. The association between the socially constructed gendered identity of professional nursing and the shaping of this as a personal identity by individual women who become nurses is explored here through written and verbal reconstructions of the processes of becoming a nurse. These accounts reveal how individuals negotiate the gap in discourses between social perceptions of the nursing self and personal conceptions of individual identity.

### **Framing the self**

Writing an account of ones' own life can take several forms, of which diaries, memoirs and autobiographies are the most well-known. Each of these forms frames experience in a set of generic conventions, recognisable to writer and reader as a way of conveying personal experience. Memoirs, for example tend to be re-collections of past events written in the present and therefore have a tendency to be episodic, highlighting events considered by the writer to be of particular importance. Diaries are usually an attempt to faithfully record impressions and events as they occur at the time. Autobiographies can use a mixture of both forms since what is constructed is a narrative, a story of a life.

The autobiographical accounts chosen for inclusion here are not intended to map the field of personal recollections about nursing lives, which is a rather vast one and worthy of a study of its own. Rather, they are a sample whose selection has been based on popularity and availability. Like the other cultural artifacts discussed in this



thesis, all are or have been widely available in bookshops and on public library shelves. As such, they have formed part of a popular circulating discourse around the image of nursing and what that image means in day to day terms to individuals who practice nursing. A principle criteria for selection was that the books should discuss general nursing training and its aftermath between the second world war and the mid 1970s, irrespective of whether they were published at the time or more recently. All five of those chosen have been written by white women trained in British hospitals in war-time and its aftermath - as yet there does not seem to be any account of these experiences written by a non-white nurse that is widely available.

The list of books in chronological order is as follows:

Monica Dickens, **One Pair of Feet**, published 1942, reprinted 1956 and 1957. This edition 1957, Penguin Books Ltd., London.

Jane Grant, **Come Hither Nurse**, published 1957, 5th edition 1963. This edition 1957, Pan Books Ltd., London.

Joan Markham, **The Lamp Was Dimmed**, published 1975, Robert Hale, London.

Lucilla Andrews, **No time for Romance**, published 1978, Corgi Books, Transworld Publishers Ltd., London.

Joan Ash, **Catch Me a Nightingale**, published 1992, Robert Hale, London.

The publishing and reprint dates of these autobiographies roughly correspond with the cyclical popularity of medical melodramas identified in Chapter 1, with peak moments in the late 1950s and early 1960s and a re-emergence in the mid 1970s with the massive popularity of the TV series **Angels**.

Writers of autobiographies tend to be highly motivated individuals who consider that their story is worth telling and that there are sufficient numbers of people interested in the life and or the lifestyle they are revealing to want to read about it. In the case of the nursing autobiographies studied here, the stories tend to divide into two categories: those written by writers who have at some point experienced nursing training and/or practice, but see it as a secondary activity to their writing career (Dickens, Andrews, Grant) and those who have spent their lives as nurses and are writing their memoirs (Ash, Markham). Collectively, they present an image of a generation of women of similar ages becoming nurses; individually, they represent a range of viewpoints on becoming a nurse and nursing's more immediate past.

The study of women's autobiographical writing has tended to become lodged in departments of literature, where there is an emphasis on the works of well known authors, although autobiographies by working-class and Black writers are increasingly on the agenda. In her introduction to an edited collection of writings on women and autobiography, Estelle Jelinek comments that many autobiographies written by women tend to omit references to their working lives, concentrating instead on the domestic and familial (Jelinek 1980: 9). That cannot be said of any of the autobiographies under consideration here; the working self is seen as the core of the autobiographical 'I' whether that self is constructed primarily as a nurse or primarily as a writer. Jelinek also points out that women writers are unlikely to reveal painful and intimate memories, in spite of claims that autobiography is self-revelatory and confessional. Whilst that may be true of the autobiographies of famous literary figures, it seems less applicable to these works; Andrews, Ash and Markham engaged this reader

precisely because of their intimate accounts of their working lives.

Before discussing the books chosen here in detail, attention needs to be drawn to the relationship between autobiographical writing and its status as truth. Feminist scholarship, with its avowed commitment to the relationship between the personal and the political, has found in women's autobiographical writing a form which seems ideologically appropriate to feminism. Lury (1991) considers that the use of the first person pronoun in autobiographical writing can be seen as indicative of subjective awareness, implying a degree of political self-consciousness at least as far as it claims an authorial right to speak of personal experience. The authenticity of autobiographical writing has however been extensively criticised from within feminism as well as from without on the grounds that although the heroine (sic) is presented as a self speaking subject, the writer remains tied to traditional forms and values such as the use of linear narrative and an emphasis on female sexuality as the key to women's identity. This raises problems for a feminist analysis because of an underlying implication that biology is destiny, that sexual difference is the essential difference between men and women, rather than the social constructs that have been built on the basis of that difference (Lury 1991: 95-108). Elizabeth Wilson sums up this dilemma succinctly, 'Not only is much fiction autobiographical; all autobiography is in some sense fictional - the remembrance or the searching again for the 'lost times' is never just an act of memory or research, but is inevitably a re-creation, something new' (Wilson 1988: 21).

Nonetheless, autobiography as a feminist methodological tool can serve to illuminate

the process of negotiation entailed in becoming a feminine subject. Contemporary feminist writings have begun to use autobiography as a way of exploring subject formation and generational change. For example, Liz Heron's (1985) edited collection **Truth, Dare or Promise: Girls Growing Up in the Fifties** presents a range of accounts from women who later became feminists, Carolyn Steedman's (1986) **Landscape For a Good Woman** explores theoretical constructions of 'working-classness' in relation to their inability to address her mother's life, and Valerie Walkerdine's (1990) **Schoolgirl Fictions** critiques her early working life as a primary school teacher. All explore the feminist axiom that the personal is political from a range of theoretical perspectives.

Women's autobiographical writing is of significant interest to feminist sociologists and historians, who are less concerned with the aesthetic forms in which experience is mediated and more concerned with the content of that experience as a representation of daily life. The autobiographies I am going to discuss here fall into this latter category. Written as transparent images of personal experience for a popular audience of primarily female readers, they contain little of interest to an aesthetician; as social documents however they provide insights into the construction of gendered nursing selves, not only in their descriptions of material circumstances but in their attitudes to the processes of professional assimilation. My intention is to use these documents to examine Dorothy Smith's (1988b) concept of 'femininity as discourse' and illustrate a commonly cited Marxist axiom, presented here in a somewhat bowdlerised form : that women make their own lives and tell their own life histories, but they do so under conditions not of their own choosing.

The aesthetic and philosophical problems raised by the feminist use of autobiographical writings pertain to a particular representational form of the self; this self clearly has some control over the forms (both aesthetic and institutional) through which such self re-presentation might occur. These writings illuminate aspects of what it means to experience life gendered female, but much of that experience continues to be unknown - not because, as Freud suggested, woman is a dark, unknowable other, but because women do not control the institutions and practices in which dominant discourses are developed.

As Benner and Wreubel (1988) have pointed out, this is part of the problem faced by professional nursing; some of the expert knowledge of practicing nurses is passed on orally because the existing discourses are unable to convey certain kinds of information, particularly that pertaining to intimate body care. Lawler locates the problem as an issue of power/knowledge, located quite specifically in an inability to discuss what nurses' work with patients actually involves because aspects of body care are privatised in 'civilised' society. This aspect of nurses' work, because there is no socially acceptable way to publicly acknowledge it, has been socially constructed on the basis of its invisibility, written off as 'women's work' and given low status in society (Lawler 1991: 219). Until recently, discussion or debate about this work has tended to be subsumed under the melodramatic rubrics of 'tender loving care', with an implied devaluation of the skills involved in the art of caring. (See SA's comments below, and note her embarrassment about using a non-academic speech register in the formal interview setting.)

Within this overall context, the use of case studies of nurses' lives can therefore be seen as part of a broader feminist and nursing endeavour, to give voice and material substance to the experiences of women whose stories and knowledges remain untold and unknown in the public realm.

### **Framing others**

The use of case studies is grounded in social science methodologies of empirical investigation and reportage. As a technique, it has been of particular interest to feminists working in oral history, sociology and anthropology. As a feminist methodology, the case study approach has been exemplified by the work of anthropologists like Mascia-Lees, Sharpe and Cohen (1989) who stress the political applications of such studies in the fight for equal rights for minority groups and the formation of policy; it has also been used by oral historians like Elizabeth Roberts (1986) to insert knowledge of women's lives into the official fabric of the past.

In this study, the primary purpose behind the use of case studies was to try and discover if the images of nurses in general circulation seemed to have any meaningful impact on young women who became nurses during this period. Why had they decided to become nurses? What factors were responsible for their decisions? Case studies were seen as an appropriate means of investigation given the scholastic constraints of a three year project where it was necessary to do a considerable amount of empirical work to identify the objects of study. Discussions with a number of social scientists about the practicalities and methodological problems of case studies convinced me that it was important to try to obtain stories from those who were least

likely to be represented in the existing histories of nursing. This entailed thinking about the nature of nursing work and how it was demarcated from other tasks, the range of institutions in which this work took place, the system of value given to work in certain medical specialities and the differences between people working in these various areas.

Issues of race, class and sexuality tend to have been absent from conventional histories of nursing. I wanted to ensure that the case studies included women who were born outside the British Isles, women who came from working-class backgrounds and women who discovered a lesbian identity in the process of nursing training. I was successful on all accounts. Additionally, I have included case studies of women who left nursing and did not return, either because of domestic responsibilities or because they decided to change their careers. I have also included two studies of women who arrived in Britain to train as nurses, but spent their working lives as auxiliaries. The main criteria for the selection of the case studies was that the person was likely to tell an untold story, one that official histories of nursing had not yet fully recorded.

In research such as this, it is customary for the informants to remain anonymous; the following brief introduction to the nurses who have contributed to the study is intended as a brief profile for the reader.

O Came to Britain from Ireland for general nursing training in Coventry, early 1950s.

She now works one night a week on a midwifery unit, Dorset.

SA General training, London teaching hospital, early 1950s. Later, a health visitor and marriage guidance counsellor. Currently undertaking further academic study and

research.

V Came to Britain from Barbados to train as a general nurse in Kent, early 1950s. Became an auxiliary nurse in a geriatric hospital and has worked as an auxiliary since then, primarily caring for the elderly.

SC Pre-nursing school entry to general training, municipal hospital, late 1950s. Worked in casualty and theatre until becoming a district nurse early 1970s. Until recently, university lecturer in district and community nursing.

G Came to Britain from Barbados to train as a nurse, early 1960s. Small, semi-rural hospital in Yorkshire. Upgraded her SEN qualification to SRN late 1960s. After eighteen years as a hospital Sister, has left to work as a practice nurse.

J General training, London teaching hospital, mid 1960s. Spent several years as a health visitor. Currently a lecturer and reader in psychology.

Ly Came to Britain to complete her schooling and train as a nurse. Commenced pupil nurse training at a municipal hospital late 1960s; worked for sixteen years, special care baby unit; upgraded qualification to SRN, now staff nurse, surgical ward.

M Came to Britain to train as a nurse in the early 1960s but failed to secure a training place. Started working as an auxiliary in the early 1970s.

MS General training, provincial teaching hospital, early 1970s. District nursing, followed by a degree in sociology and counselling training. Now nurse and student counsellor, higher education institute.

Ju General training, provincial teaching hospital, mid 1970s. Later, became a community midwife. In the process of leaving nursing for a new career.



Much like other academic research based on qualitative methodologies, my sampling has depended on the willingness and good faith of those who agreed to be interviewed. The ten women above donated their time and energy to this project, and I am aware that I now have a responsibility to represent their views as objectively as I can. Their accounts are however inevitably highly mediated; shaped by the open ended structure of the interview, the transcription process from spoken to written language, the way in which I have incorporated them into this piece of writing and the formal structures of doctoral thesis writing. As the researcher, I have controlled the selection of speaking subjects, influenced the style in which their life stories are presented, chosen the theoretical framework within which that telling is analysed, and drawn any conclusions that emerge.

In an illuminating article, Caroline Steedman outlines an approach to the relationship between autobiography, biography and history which is a useful adjunct to the methodologies outlined briefly above. Steedman draws a parallel between the use of autobiographical narrative in the construction of the self as a unitary subject of discourse, and the use of narrative in historical discourse to create a sense of linearity and progress. To quote her more fully:

‘Written autobiography ends in the figure of the writer...the man or woman writing a book is the embodiment of something completed. History is a narrative that proceeds by the objectives of exhaustiveness and exception; and its central rhetorical device is this recognition of temporariness and impermanence. The fictionality of all these forms can be suggested...forms of writing that work by emplotment, by the use of figures and allusions, as

well as by the presentation of their content, which is information about lives and times' (Steedman 1989: 110).

Autobiography, biography and history are used in this chapter to create a layered narrative that ends not in the happy ever after of a stable nursing self but in the figure of the feminist researcher, a constructed entity that can weld the personal and the public into the potentially political.

## Part 2

### Self image and uniform identities.

*'The relationship between the image, a point of view and "an involvement in the real" problematises any simple tale of the self'*

(Probyn 1993: 105).

In the immediate post war aftermath, the status of the nurse in the public imagination as a 'ministering angel' was at its peak. There appear to be three main reasons for the high status given to those doing nursing work at this time: one was the introduction of the newly nationalised health services which, for the first time, made medical and nursing services freely available to all as of right; the second was a collective memory of the nursing care given to the injured, sick and dying in the extreme circumstances of a war in which civilian as well as military casualties had been high; and thirdly a dependency on nursing care for surviving 'the crisis' of infectious diseases in the days before the development of effective drug therapies.

In chapter one, I examined the popular fictional image of nursing circulating in films and career novels for girls and concluded that between the war and the early 1950s, nurses were imaged primarily as self sacrificing 'angels of mercy', driven by a vocational zeal that had much in common with a religious calling. In chapter two, I argued that the profession, led by the General Nursing Council, used government (un)employment agencies and the careers service to promote a vocational image of

nursing as 'a social service' to young, upwardly mobile women from working-class backgrounds. The elite teaching hospitals on the other hand used only the Nursing Recruitment Service and the Association of Headmistresses; they emphasised the 'social value' of nursing, playing down the vocational aspect in favour of presenting high flying career opportunities for those of 'marked ability and high educational standards'.

Underlying these two recruitment strategies are taken for granted assumptions about the relationship between women of different classes to popular fictional representations. It was assumed that lower middle and working-class girls would be receptive to melodramatic, emotional appeals, whereas middle-class girls would need to be convinced through rational statements that a career in nursing would enable them to achieve a high social status. The development of the two tier training system reflected a belief that lower-class young women would make good practical nurses and should therefore be trained to remain at the bedside (the enrolled nurse) whilst middle-class young women would enter general training and organise the delivery of nursing services. It was assumed that the former would be more responsive to a romantic ideology of vocational service and that the latter would insure that this ideology was maintained. In practice, trainee nurses either absorbed the vocational ethos or treated nursing as a job that had to be done; if they continued to be hospital nurses after qualification, some would undoubtedly wear the veil of vocational idealism. MS described these women as the epitome of the professional nurse:

'These nurses were definitely professional women, they would argue that nursing was a vocation and if the salary increased it would attract the wrong

type of girl’.

This ethos still pervaded provincial teaching hospitals in the early 1970s.

Becoming a nurse is both a personal and a public process. At the personal level, an individual decides to undertake a programme of training which will enable them to practice nursing professionally and earn a living from it. At the public level, individuals are schooled to be cognisant of the parameters of the role of the nurse and become licensed as safe practitioners after a prescribed period of training set down by official government and professional bodies. To become a nurse is to take on both a personal and a public identity, an identity that was symbolised throughout the period of this study by the traditional nurses’ uniform. This uniform has historically played a central role in nurses’ self-image and is inseparable from the common stereotypes of nursing identified in Chapter 1; the ‘ministering angel’, the ‘battleaxe’, the doctor’s handmaiden and the sexy nurse.

In becoming nurses, young women took on both public fantasies and professional ideals as they donned the uniform. One of the questions that this section of the chapter tries to answer is to what extent individuals who became nurses were aware of these conflicting images of nursing and how they impacted on the processes of professional assimilation.

In **Landscape For a Good Woman**, Carolyn Steedman describes her mother’s preoccupation with the fashionable 1950s ‘New Look’, in spite of the prohibitive cost of the clothes for ordinary working women during the years of post-war austerity.

A similar pre-occupation with fashion and clothes is foregrounded in many of the nursing narratives of the period. In the popular nursing 'career girl' novels, how you looked as a nurse, both on and off duty, is of paramount concern. Clothes are used to identify the different types of young women who begin nurse training in Ealing's (1956) film **The Feminine Touch**. In Jane Grant's (1957) autobiographical description of her training in the 'fifties **Come Hither Nurse**, accounts of fashion as a rebellion against dominant ideas of 'fifties femininity and the uniform restraints of nursing serve as a reminder that the relationship between fashion, femininity and nursing was by no means simple and straightforward.

By the late 1940s, the traditional uniform was already bearing a number of meanings far removed from the control or influence of professional nursing's orbit. The meanings it evoked were a source of both pride and embarrassment to nursing leaders. On the one hand, it was a symbol of traditional female authority and social status; those who wore it were seen to occupy a certain position in society. This was particularly true in the former voluntary hospital sector, where many of the uniforms had changed little since Victorian times. Some of these uniforms bore a direct connection to nursing's religious past; for example, many of the caps worn by trainees were similar to the veils worn by novice nuns, evoking comparable notions of purity, self sacrifice and vocational duty to a higher ideal. J's memories of beginning her training in the mid 1960s at a well known London teaching hospital recall that even at this time, the religious connotation was still very strong. Etched in her mind is an initial image of religious vocation and duty:

'We were met with what looked like a nun who was in fact our tutor, who

was clad in blue and with this sort of cap that came down over her eyebrows and hung down her back. I remember it vividly, it was just like joining some kind of mission really’.

Some uniforms were more reminiscent of Victorian parlourmaids’ dresses, with stiff white aprons and starched white collars, frilly hats and thick black stockings. Recent feminist research has revealed the connections between Victorian female servants and the production of erotic literature and photographic images (see for instance Stanley’s introduction to her editing of Hannah Culloch’s diaries [1984] and Davidoff 1983); nursing has also provided a stream of imagery to feed the pornographic imagination. Soft-porn images of scantily dressed nurses showing their brassieres and suspenders (as in the **Carry On** films) are but the tip of an iceberg of submerged pornographic representations featuring nurses.

Some uniforms combined the plain apron of domestic service with the lace cap of a lady and the starched eton collar of the male officer class, displaying the fragmented historical identity of a profession riven by issues of class and status. Young women wearing these uniforms were not only announcing their status as nurses to others, they were literally wearing nursing history, enveloping themselves in the ghosts of nursing’s formidable ‘foremothers’ and their determination to make nursing a respectable profession. Starched white aprons, high white collars and stiff white hats tend to signify an almost untouchable purity, calling to mind the ‘cleanliness is next to godliness’ cliché. But nursing as a job necessitates that you come into contact with other people’s bodies and their excreta; in many ways, it is a ‘dirty’ job. Nurses

become familiar with the physical bodies of patients who are basically strangers, and as a result of this contact develop considerable knowledge about bodily functions. This kind of knowledge was still considered unseemly for 'genteel' middle-class young women brought up in the post war period, whereas working-class girls, judged by middle-class sensibilities and standards, were assumed to be 'closer to nature', more physical and therefore more familiar with (and in need of less protection from) the physical needs and demands of the body.

The image of nursing has always tended to embrace both of these feminine stereotypes; on the one hand, an asexualised feminine purity and on the other a more sensual, physical familiarity. In some ways, the uniform was a great leveller, communicating contradictory messages of both untouchable purity and comforting 'down to earthness' to those they cared for. Class issues tended to be subsumed by the uniform. Anyone wearing it was open to being seen not only as a virginally pure 'angel of mercy' but also as a worldly wise motherly type or a provocative, sexy female. A tantalising combination of angelic innocence and earthy experience could be invoked by a patient no matter who was wearing the uniform. This ambiguity lies at the heart of nursing's image.

Most nurses have had to cope at some time with this ambiguity, which can take the form of anything from good humoured quipping from primarily male patients through to blatant sexual harassment (Ash 1992, Lawler 1991). Lawler considers that the lack of (reported) sexual harassment of staff working in same sex situations is at least partly due to codes of containment in lesbian and gay sub-culture which define



specific places of acceptable sexual expression, whereas sexuality is a pervasive aspect of heterosexual social life (Lawler 1991: 213). The attitudes of female patients to female nurses are more difficult to determine; the lack of research in this area tends to suggest a continuing 'taken for grantedness' in encounters between same sex nurses and patients. Lawler (1991), for example, focuses on male patients and female nurses in her detailed account of how nurses manage the bodies of others, although she does mention male nurse/ male patient encounters. Broadly speaking, it is likely that the views of female patients were not very dissimilar from the women surveyed in the National Public Opinion Poll, where working-class women tended to bestow nurses with an 'angel' image, but middle-class women viewed them more as a specialised type of servant - a view shared by those who defined nursing and domestic work as virtually analogous in the 1949 Nurses Act. Lucilla Andrews comments on how working-class female patients often managed their stay in hospital through a sense of camaraderie, sharing good humoured bawdy jokes and banter that she rarely understood (Andrews 1975: 113). My own memory is that many nurses actually disliked nursing women, particularly on the private wards where the middle-class patients were considered 'over-demanding'. But most of this antipathy was based on the burdensome nature of the work load on the female wards - the endless round of bedpans and heavy lifting. Some female patients certainly identified nursing as hard work, but others expected it as a right, as part of the hospital service.

Amongst the nurses interviewed for this project, opinions varied considerably about the degree to which they were either regarded as untouchable 'angels' or personally subjected to various forms of sexual harassment. O, who started her training in the

early 1950s, commented as follows:

‘People, especially Coventry people, held the nurses in great esteem and respected them and looked up to the trained staff especially and I thought, oh yes, one day I’ll be there in that position’.

This experience seems close to that of autobiographer Lucilla Andrews, who trained as a nurse in war-time Britain and talks only of the praise and respect nurses received from the general public. On the other hand, SA, thinking about her training at a London teaching hospital in the early 1950s commented:

‘I never quite established how it was that when you were out, men always seemed to know that you were a nurse, whether you stunk of disinfectant or what. You were either an easy lay or an angel, one or the other’.

SC trained at a large municipal hospital in the late ’fifties. She pointed out that there was a great division amongst trainees between the ‘party goers’ and the ‘save souls’. This distinction did not mean that the former had loose morals or that the latter were particularly religious, but it did mean that ‘party goers’ bore the brunt of being branded ‘easy lays’, whereas ‘save souls’ of course did not because they tended not to socialise. These images were still circulating in the 1970s. MS knew that nurses had a ‘bad reputation’ when she applied to do her training at the local teaching hospital;

‘There was a slag image, but we were above that, I didn’t feel tainted by that’.

It is interesting to note that SA, insecure in her social status felt ‘tainted’ by the whore image as I did myself, whereas someone secure in their middle-class identity felt completely immune from it.

Whoever wore a nurses uniform can therefore be seen as a personification of angel/sexy nurse stereotypes, which are a specific variation of the virgin/whore dichotomy. These binary oppositions are likely to be ascribed to nurses somewhat indiscriminately, irrespective of class background or the status of the hospitals that they work in. To become a nurse throughout this period was on the one hand to wear a denotive sign of public service to the community with associated connotations for some of an underlying liberal (paternalistic) ethos; on the other, nurses evoked personal fantasies of erotic sexual practices embedded in the public imagination. An individual nurse could be seen as any (and sometimes all) of the spectrum of illusions ranging from self sacrificing angelic purity, through visions of hard work and authoritarianism, to fantasies of carnal knowledge and sexual voracity.

One way that the nursing profession has tried to overcome and change these images of itself is through modernising the uniform. Until the late 1960s, changes largely consisted of modifications in dress fabric, length and design; then a slow programme of national reform began. In practice, nurses have always tended to modify their uniforms to suit the style of the day by altering small but significant details; for instance, folding hats in more stylish modes, wearing non-regulation shoes and altering the width of their belts, but this was fairly strictly controlled by peer group pressure to conform to professional ideals.

‘They were very, very strict...I don’t think we dared mess around with the uniform. What we used to do of course was to pinch our waist in so that we could hardly breathe, it was obviously important that we had this sort of hour glass look’ (SC).

‘(The uniform) had to be 13 inches off the ground and we had these big hats, all stiff and starchy, black stockings and black shoes. You wouldn’t go round with dirty shoes, they were very particular, very strict’ (O).

Several nurses commented on how uncomfortable these uniforms were, and how the stiff collars rubbed the neck:

‘Very uncomfortable, it was like wearing mattress covers...it wasn’t an attractive uniform’ (J).

These nurses claimed, however, that the traditional uniform did have a use function, and it is perhaps this aspect that has been least taken into account by critics such as Salvage (1987). For the individual wearing it, the uniform was a crucial interface between a vulnerable private self and the public world of the hospital with its cryptic language and rituals. In this sense, its protective function went beyond the mere practicalities of keeping yourself clean; for the novice nurse, it conferred authority and status and gave her the initial confidence needed to approach strangers and carry out nursing duties:

‘In those days the nursing uniform was something to wear...so that when you put those on you know, you feel quite important really...’ (Ly).

‘I just assumed an identity that was quite important for me, that made me feel quite strong and powerful...with me uniform on at work, it gave me a lot of confidence, yes’ (Ju).

‘It was obviously quite important to me as a young woman, as a young girl to be wearing a uniform...we were very, very proud; it was all part of the rites of passage’ (SC).

‘It felt brilliant’ (G).

As well as conferring authority and status, the uniform had a protective function, enabling the wearer to perform personal acts of body work on complete strangers. It was both a tangible and a metaphorical barrier, functioning in a similar way to the bar counter that separated Victorian barmaid from their (sometimes lascivious) customers (Bailey 1990). Most of the nurses in this study felt that the traditional uniform was in some sense an integral part of their identity as nurses, for all the criticisms they might have of it.

Perhaps this is unsurprising; all but one worked in hospitals in the days when various forms of the traditional uniform were still worn whether you entered the profession as a cadet nurse, a student, a pupil or an auxiliary. In one way, the uniform was a great leveller. As long as you wore it, to the patients you were a nurse, no matter what hierarchical status values were professionally attached to differences in caps, belts and dresses. In another way though, the uniform was a great divider, keeping the different grades of nurse strictly apart and maintaining rigid hierarchical boundaries within the profession.

The uniform has been on and off the nursing policy agenda since the Briggs report in 1972, when it was pointed out to the profession that the image they projected to the public was in urgent need of modernisation. The introduction of the national uniform for nurses in the wake of this report has remained a bone of contention amongst nurses. In her autobiography, Joan Ash describes her return to nursing in the mid 1970s after a long absence spent bringing up her family. Her biggest shock is not the modernisation of treatment and nursing services, but the fact that the nurses

are all wearing 'Jeyes cloths'. Instead of finding nurses, Ash felt she had landed amongst a group of Marks and Spencers shop assistants and that,

'Without the linen aprons, the familiar figure of the nurse had faded into history' (1992: 58).

A similar feeling is expressed by J, even though she is critical of the uniform she had to wear as a trainee:

'The national uniform probably did more for lowering the self-esteem of nurses than any other single act. I think how can people feel good about themselves when they're forced to put all shapes and sizes into such ridiculous sorts of uniform...it makes you feel not valued, and I think nurses have gone through quite a long period of not feeling terribly well valued' (J).

This sense of not feeling valued is clearly felt by Ly:

'These days, (the nurses uniform) don't really mean anything. Its horrible now - the girls in Littlewoods dress better than nurses today. There's not much pride in it' (Ly).

O feels that the loss of the traditional uniform is part of a much broader decline of the status of the nurse and nursing in society:

'Put that uniform on and you were a nurse. If a policeman puts the uniform on, you'd expect him to be a policeman. That's what everyone thinks, you know, and now we're going to lose the lot. We're going to lose our hats and aprons. I think everything is going' (O).

This is tied in with a sense that the public now see nurses very differently, something that Ash dwells on at considerable length. No longer are nurses respected authority figures or comforting pseudo mothers; the public has a much less romanticised picture

of nursing. In Ash's text this is demonstrated by example; it is peppered with accounts of patients physically assaulting the nursing staff. These assaults occur more frequently as her account moves into the 1980s.

This loss of respect and value is seen by some nurses as a direct result of an increasingly militant attitude which puts professional and personal needs before those of the patients. Markham, for example, writing in the mid 1970s is highly critical of professional preoccupations with pay and conditions of service, and sees them as primarily responsible for changing public attitudes towards nursing;

‘I am grateful for the better salary and the better conditions, but I think that a lot has been lost in the gaining of these, and that we must accept that there is something intangible in the old fashioned word ‘vocation’ (1975: 167).

In contrast to this view, Ash displays a determined militancy against a bureaucratic system which she feels is systematically destroying her professional values and beliefs. Entering the profession from a strict Christian upbringing, Ash became a vocationalist after her initial training in the 1940s when she ‘fell passionately in love with nursing’. By the 1980s however her own image is not one that sits easily with traditional ideas of vocationalism and self sacrifice although her fight is in part about protecting those ideas and values from further erosion.

Others view the change in public attitude with more mixed feelings; for these nurses, the loss of professional aura is seen as the direct result of a more informed and educated public on health and medical matters. Higher standards of general education, and specifically more information about their own bodies has accompanied

a general loss of public belief in the miraculous powers of modern medicine that so characterised 1950s society. As O rather regretfully stated,

‘There’s no secrecy, everybody knows what we do and there’s no barriers anymore’...

For Ly, this change in attitude has practical implications in administering treatments because patients have the right to say ‘no’.

‘I felt the attitudes then were a lot different to what they are now...they had a lot more respect for you and whatever you say, they would do it, they felt that you know best. I suppose they put all their trust in you really...they’re a lot more educated these days. They ask more questions, they know a lot more about their body’ (Ly).

Whether these changes in public attitude towards nurses can be attributed primarily to an increase in public knowledge about their bodies, or to consumerist lobbies that have fought for more rights for patients in health care practices (a movement that in some ways culminated in the Patients Charter of 1992) is not a question that can be answered here. The question of status is however of vital importance in the new market economy of health care in terms of nursing’s ability to continue to be able to differentiate its services from those of other para-medical professional groups. It is also of vital importance in recruiting young women and men into the profession, for if nursing’s professional status is low, those seeking satisfying careers will be more inclined to enter fields where the rewards, in both status and financial terms, are greater. The following section examines questions of status through the representation of two of nursing’s other popular images, the battleaxe and the handmaiden.



### **Part 3**

#### **Knowing your place: hierarchy, status and the self.**

In Chapter 2, I discussed professional nursing's divided identity; two main points were made that are relevant to this section. The first is that by the early 1950s, general nursing had become hegemonic: state registration as a general nurse became the main portal of entry to all careers in nursing, the gateway to professional status and a wide variety of further qualifications in specialised fields. Other trainings, such as fever nursing or sick children's nursing began to be seen as specialised additional trainings, although it was still possible to practice in these areas without a general nursing qualification. The second point is that there continued to be an acute shortage of people who wanted to do nursing work; the newly nationalised health service increased the demand for nurses, with the result that the recruitment net was spread over a vast new (for nursing) source of labour. This included the setting up of special pre-nursing schools attached to the new 'modern' schools, as well as recruiting more candidates from nursing's traditional source of immigrant labour, Ireland, and extending recruitment drives to the 'new commonwealth'.

All the nurses interviewed for this study wanted, at some point in their lives, to become state registered general nurses although for a range of reasons not all of them achieved their ambitions. Of the autobiographical writers, only Dickens withdrew from training; the rest became qualified general nurses, but only Ash and Markham worked as nurses for long periods of their lives. As I pointed out in the introduction

to this chapter, research into why women became nurses at this time tended to emphasise the centrality of girls' attitudes to nursing; this was interpreted by nurse trainers as a desire to help 'suffering humanity', but there is no empirical evidence documented that supports this view.

Given that there was an acute labour shortage in nursing, relying on the vocational image was clearly an insufficient answer to the problem of attracting the large numbers of young women that were needed to staff the wards. In Chapter two, I argued that nursing leaders who supported the management ethos of the new NHS used a variety of popular fictional images of the nurse to appeal to young working-class women, as opposed to the more traditional 'lady of the lamp' ethos used by the professionalisers. In this section, I want to look at the images of nursing interview respondents think they remember having before they became nurses themselves, and to explore the relationship between these early memories and the later experiences of professional assimilation.

Before that however, I want to look at some of the images of becoming a nurse constructed by women writers who worked as nurses. Monica Dickens was probably the single most influential portrayer of nursing identity throughout the 1940s and 'fifties. Her autobiographical novel **One Pair of Feet** (published 1942) based on her experience as a first year nursing trainee led to a film adaptation **The Lamp Still Burns** (1943), and to co-scriptwriting a nursing recruitment feature film commissioned by the Crown Film Unit for the Ministry of Information, **Life in Her Hands** (1951). Dickens had the support of leading professional nurses in the

influential London teaching hospitals as well as the Ministry of Health. Her work was popular and found a wide and appreciative audience, perhaps because as *The Listener* commented in a quote published on the book cover ‘Miss Dickens succeeds, almost in spite of herself, in conveying the essential nobility of the profession and the supreme satisfaction of a life saved’ (Penguin 1957 edition).

The comment ‘in spite of herself’ sums up Dickens’ view of the nursing profession rather succinctly. Although she admires the values espoused of service, self-sacrifice and dedication to a higher ideal, she finds nurses themselves a rather dull and uninspiring group of women, riven by petty snobberies and class discrimination. A great-granddaughter of the author Charles Dickens, Monica was privately educated and presented at court in 1935. She therefore occupied a markedly different social position in English society to the majority of the young women who were becoming nurses in wartime Britain. Her sardonic attitude to the majority of her nursing colleagues conveys this sense of class difference very clearly. The text is littered with references to their aspirations ‘to set (themselves) on a higher plain than their fellows’ (1957: 117), a form of snobbery which Dickens, from her secure position in the upper echelons of the social hierarchy, considered ‘odious’. Although she ironises the attitudes of those in her peer group who object to being bossed about by ‘uneducated women with no breeding’ (1957: 79), it is clear that she finds the airs and graces adopted by those of a lower class than herself amusing, especially given the menial, servicing nature of much of their work. Commenting on hospital etiquette at this time, she says, ‘I was always dropping bricks and addressing people as equals’ (1957: 33). What comes across overall is a picture of a confident and articulate upper

middle-class young woman whose difficulties in coping with the servile nature of much of the work she had to do were emphasised by her low status position in the hierarchical hospital system. As she wryly comments near the beginning of the book, 'Several people had told me that they tried to resist the hospital system at first and had ideas about revolutionising the whole thing. But you can't; it's too big and too rooted' (1957: 36).

Reading this autobiographical novel in 1993, Dickens's achievement is perhaps more markedly one of being able to convey something of the mindset of a young upper middle-class woman in early 1940s Britain. The desire to explore and write about the lives of women from different backgrounds to herself using methods of participant observation has similarities with the work of her contemporary, George Orwell. These war-time 'ethnographers' had much in common with their Victorian literary predecessors like Charles Dickens and Charles Kingsley - a desire not only to reveal social injustice by informing and educating the reading public, but also a commercial incentive to entertain and amuse. Monica Dickens, however, lacks the radical liberal humanist edge of Orwell; at times her satire serves only to mock the women she observes, without profering any insight, deeper questioning or analysis into either their institutional positions as female health workers, or the formation of their subjected positions as self-sacrificing carers of the sick.

Dickens describes a series of possible options for working-class women called up for public service in war-time Britain - in the services, the land army, and the auxiliary fire service, all of which, apart from nursing, she claims to have rejected because of

the hard physical labour involved. Opportunities for upper and middle-class women in war work, such as the Women's Royal Voluntary Service, she dismisses as essentially smallminded. She claims that she chose nursing not only because 'It's one of those adolescent phases like wanting to be a nun', but because she saw Madeleine Carroll in **Vigil in the Night** (1939) at the cinema.

'I was going to be a nurse in a pure white halo cap, and glide swiftly about with oxygen cylinders and, if necessary, give my life for a patient' (1957: 9).

Dickens' ironises here both the sentimentality of nursing's vocational ideal, and the appeal of that sentimentality dressed in melodramatic form for a female cinema audience. On the one hand, she distances herself from this ideal through the implicit critique of her irony; on the other, there is a wry admission that there is something noble about living life in the service of a higher ideal. Whilst she emphasises her awareness of popular fictional forms, and as a ('middle brow') writer of literature, her own critical distance from them, she also acknowledges the powerful emotive forces generated by working in life and death situations; emotions which popular melodramatic forms can convey so aptly.

This critical, ironic stance does affect how Dickens's account of becoming a nurse can be interpreted. Her oppositional position can be read as grounded in a distrust of images that play on an emotional need to be needed; her middle-class sense of her own self worth could be aware that exhortations to women to devote themselves to others can be exploitative, so she is suspicious of nursings' traditional, self-sacrificing image even in war time. Dickens was clearly aware of contemporary feminist arguments that were arguing for equal rights in employment; her comments about the

wages, working conditions and the need for unionisation amongst nurses show a certain sympathy with the plight of working women, although she explicitly refuses to align herself publicly with a feminist critique of conditions. Her deep suspicion of the process of institutional assimilation in nursing comes from a liberal fear of conformity as a threat to individual freedom and personal autonomy. The insularity and routine of much of hospital life changes the self because nurses are trained to obey a set of institutional rules and behavioural regulations, not to use their initiative or express an opinion. Unambitious conversation and the 'unsubtle, lavatorial humour' make Dickens feel dull and inadequate in other social circles (1957: 203). Nurses were not expected to take an interest in the outside world, and nor did the outside world, she claims, expect nurses to be interested in outside events (1957: 42). They were regarded, by and large, as 'a race of screaming bores' (1957: 95).

It is perhaps not so much that Dickens disliked nursing work per se, but the rigid, hierarchical structures in which that work took place. Almost in spite of herself, Dickens does find nursing fascinating and in a way fulfilling. Something of the personal drama of facing her own fears and prejudices comes through in her accounts of life and death situations. Although her descriptions of patients, similarly to her descriptions of the nursing staff, tend towards a caricature of 'working-classness', she is aware of patients as people, and aware of a system of health care that perpetuated anxiety and distress amongst patients because of its refusal to share knowledge with them. She is able to discriminate between those Sisters who ran their wards in an atmosphere of care and concern and those who created mini 'totalitarian states', treating nurses and patients alike as mindless imbeciles.

In the films that Dickens wrote, this more positive attitude is foregrounded, and nursing is portrayed as a worthy career for their leading protagonists, young middle-class women. Given however that the film audience throughout this period tended to consist of women from working and lower middle-class backgrounds - nursing's traditional source of labour - it can be argued that the melodramatic aspects of the films were presumed to appeal to the romantic, sentimental emotions of the female audience. At this time, there was widespread general agreement on the political left and the right about the susceptibility of women (and by implication, this meant lower-class rather than middle-class women) to manipulation through the ideologies of mass cultural forms. Dickens seems to have been aware of these theories, demonstrated in the ironic parody of her own experiences of becoming a nurse and a critical distance from her own emotional responses to nursing work.

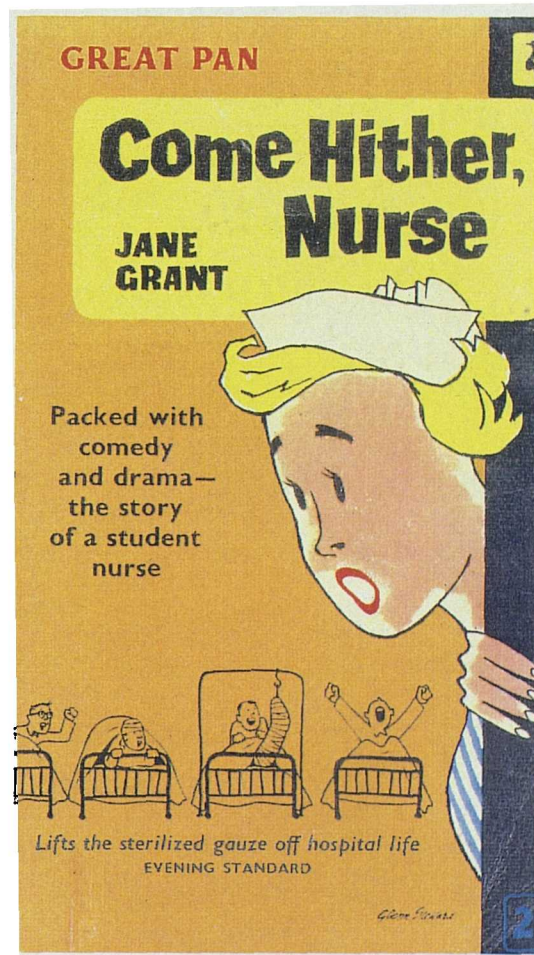
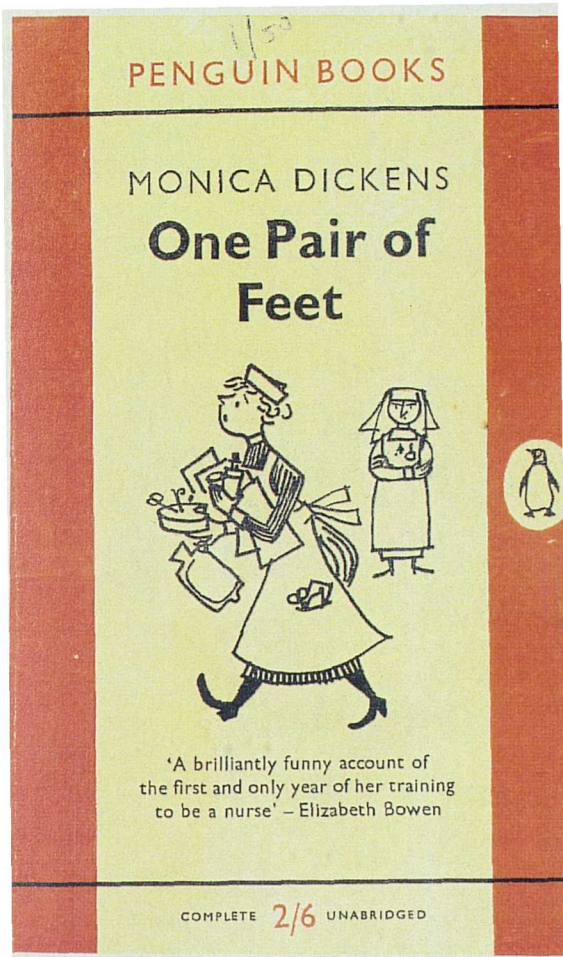
Of the five autobiographies used in this study, it is Dickens' which comes closest to Jelinek's assessment of female autobiographers. Jelinek claims that women writers are unlikely to reveal painful and intimate memories, in spite of autobiography's generic claim to be self revelatory and confessional. Intense feelings of love and hate, fear, the disclosure of explicit sexual encounters or the detailing of painful psychological experiences are generally left out (1980: 9). Women, according to Jelinek, generally write in a straightforward and objective manner about their girlhood and adult experiences; they also write obliquely, elliptically or humorously in order to camouflage their feelings. In **Come Hither Nurse** (Jane Grant, 1957) it seems far more plausible that the author has adopted an elliptical or humorous mode in order that her book will sell rather than to hide her feelings. Published at the same time

as Richard Gordon's highly popular **Doctor** books, Grant was no doubt encouraged by her publishers to adopt a similar tone in the interests of commercial success, just as Andrews was encouraged to write medical romances rather than serious novels. Contemporary critics certainly picked up the similarity to Gordon, comparing Grant rather favourably to Monica Dickens. Reading her text in 1993, the most striking similarity is not however to either of these written texts but to Ealing's film **The Feminine Touch** (1956), based on Sheila Mackay Russell's account of her training in the United States, **The Lamp is Heavy**.

Throughout her account of nursing training, Grant emphasises humour and romance rather than presenting a 'realistic' account of nursing work. The overall impression is that nurses spend a great deal of their time observing and looking after the male medical staff, rather than their patients. Doctors are supplied with constant cups of tea, sandwiches and patients' food stolen from the fridge. As well as being nurtured by this constant supply of food and drink, doctors also get their shoes cleaned, their socks washed and numerous other little chores done for them. The image of the nurse as doctors' handmaiden reaches its zenith in this account; nurses no longer administer tender loving care to sick patients, but serve medical men with passionate zeal. The handmaiden is revealed here as a specific variation of the ministering angel, with doctors supplanting patients as the objects of selfless devotion.

A reading against the grain of the text however reveals some interesting comments on the doctor/nurse relationship. Towards the end of the book, Jane is in her third year of training and has begun to notice that some of her nursing superiors know





*Plates 20 and 21:  
Late 1950s paperback  
covers. Note stylistic  
similarity to plate 11.*

considerably more than the medical staff. Aside comments in the text begin to point out how doctors use nurses' experience of problem solving to their own advantage, acting as if they had thought of the proffered solution themselves. The following extract is one of some such half a dozen exchanges in the text:

'Totally disregarding the gowns and masks we had put out for them, doctors and students started looking at and discussing the X-ray photograph of the man's jaw. It was obviously going to be a tricky job.

"Why don't you use the magnet, boy?" said Daisy (the night Sister) to the Registrar.

"Yes, we could do", said the Registrar, as if the idea had already occurred to him (which it hadn't) (1957: 109).

These exchanges bear a striking resemblance to those later observed by ethnographic researchers in participant observation studies of nurse/doctor working relationships (see for instance Stein, 1978).

Grant, like Dickens, addresses her text to the 'middle brow' market. She is writing for an educated readership who need little explanation about medical procedures or explication of medical terminology; there is a taken for grantedness about words with Latin prefixes. The author speaks as one middle-class person to another, commenting on the habits of her working-class patients as if they were a quaint species of being from an altogether different race or breed. Female patients are regarded as more depressed and sorry for themselves than the men, who are considered much more fun to nurse and better at being patients. Although Grant does not make a direct connection between nurses of lower social status and the 'empty headed gigglers' she

dismisses on several occasions, the implication throughout the text is that there is some sort of connection between class and intelligence. When it comes to her descriptions of the medical staff however, no such assumptions are made, and there are numerous references to thick and stupid doctors who are not very good at their jobs.

Grant makes few references to general attitudes to nursing, other than how it was regarded by friends and relatives as hard work. Nor are there any references to issues of sexuality, apart from having to deal with sexual innuendos from male patients. Wearing clothes that were considered 'tarty' was however definitely frowned on, and results in one of Grant's peer group being asked by the Matron to change her mufti. Detail about nursing work is rather thin, unless it involves a medical procedure with a doctor present and the opportunity for a romantic encounter. Considerable effort is spent in describing the different ways Jane and her friends manage to procure doctor boyfriends and husbands for themselves; all in all, the book is really an adult version of **Sue Barton, Student Nurse** with the emphasis on the rituals of courting itself, rather than preparing for the event of courting through concentrating on the details of clothes and make-up.

The handmaiden image that Grant describes stands in stark contrast to accounts by the interviewees, several of whom pointed out that although ostensibly organised around the care of sick people, hospitals are in fact organised around the work schedules of medical men, whose tasks of diagnosis and prescription are given precedence over the nursing tasks of treatment and care. Although nurses are

responsible for day to day observations, delivery of treatments and care of patients, their role has always been clearly circumscribed by medical priorities. In Britain, their position in the hospital hierarchy at this time was the somewhat ambiguous one - within the NHS at least - of being employed by the health authority rather than by doctors, either directly or indirectly. This means that there is no direct line of responsibility to doctors as such, but to nursing's professional bodies and the employing health authority. Nurses are theoretically responsible to other nurses in the nursing hierarchy rather than to medical men; for most nurses, contact with doctors was fairly minimal:

‘It was our job to make sure the patients were kept quiet and the beds spick and span while the doctors were going round - we had very little contact’ (J).

‘We were separated from the doctors, and not encouraged to socialise. We even had our own eating place’ (MS).

### **Training and status**

Amongst the interviewees who began their nursing training in the 1950s, none remembered reading Dickens or Grant, or seeing the films, but they did have clear memories of why they had taken up nursing as a job or career, which hospitals they had trained at and why, and how those hospitals had their own particular methods for instilling their own interpretation of professional nursing values into new recruits. In response to a question about their class status, most of the women claim working and lower middle-class origins which they now feel varying degrees of distance from, seeing class identities as somewhat fluid. Only two interviewees claimed a solid middle-class position based on their father's status. Class consciousness was more

of an issue for those who trained in London teaching hospitals; only two other interviewees expressed strong feelings about nursing's class status.

SA came from a fairly typical upwardly mobile lower middle-class family: her father was a policeman, her mother had trained as a teacher. She had no idea that such a background would make her feel inadequate when she commenced her training in the early 1950s at one of the most prestigious London teaching hospitals:

'I was aware (which hadn't occurred to me until I got there) that I wasn't quite up to it. An awful lot of them were the daughters of doctors...they were definitely middle-class, which I don't think I was'.

For SA's family, acceptance for training at a London teaching hospital was, by implication, an acceptance of their own upwardly mobile social status, a sign that they had in some sense made it, and crossed an invisible barrier in 1950s society. SA's father's response, which she remembers because it angered her at the time, was that she only had a place because he was a police superintendent, not because of any intrinsic merits she herself possessed. It was his efforts and his career success, not SA's success in the education system that he saw as the significant factor. For upwardly mobile families in the 1950s, training at a London teaching hospital had a resonance which still echoes faintly today.

These hospitals were given high status by the general public in part because of their long standing charitable associations and religious heritage, but also because of their growing visibility in television medical documentaries as pioneers of new medical miracles. The training schools had created a reputation based not only on their

historical connections and the quality of their nursing care but also on the social status of their recruits. J's family were of the opinion that if you were going to train as a nurse, you wanted the best training available, and that was to be found in a London teaching hospital. But by the mid 1960s, the class status of entrants to the London teaching hospitals was beginning to change according to J:

'Everybody thought everybody else was going to be far more superior, so everybody adopted terribly posh accents until we suddenly realised that Sally's father was a milkman, and somebody else's father was a postman, and actually we all came from working-class backgrounds, the majority of us, except for two girls who stood out whose fathers' were in the RAF. They really didn't mix well with the rest of us; to be honest, we've lost track of them'.

Nicknamed 'the lady apprentices' by their contemporaries, the nurses who trained at the core hospitals in the London teaching hospital group (primarily Guys, St. Thomas's, St. Bartholomews (Barts), the Westminster, Kings College and the London) were often seen by other nurses as snobbish, 'stand offish' and elitist. Commenting on the awareness between nurses of this internal hierarchy, and referring to the time she worked at Poole General, where the matron favoured employing nurses trained at Barts, SC pointed out how you could always tell a Barts nurse by her (superior) attitude. J was aware of how this sense of professional superiority had permeated her training:

'Barts had a very strong image of what a Barts nurse was, and at the end of PTS they actually sent away one girl because she wasn't 'Barts material' (J).

Nightingale's influence on the training and education of nurses spread far beyond the London teaching hospitals. Many of those she trained took to reforming nursing and its working-class workforce with a missionary zeal, particularly in the former workhouses and municipal hospitals. As Gamarnikow (1991) has pointed out, Nightingale equated nursing training with learning to be a 'good woman', an idea that suited the parents of upwardly mobile, 'respectable' working-class females who could no longer expect to spend their lives in service. In schools of nursing strongly influenced by Nightingale's teachings, the ethos of traditionalism with its vocationalist overtones of personal self sacrifice and duty to the patient counteracted the modernising forces of fordist managerial strategies and unionisation of the workforce. SC describes a training that seems very little different to that experienced by SA and J, although SC emphasises in her interview the role played by tradition in her professional assimilation to a greater extent than SA and J. It is difficult to assess whether this emphasis comes from her more recent feminist insights into the role of training in maintaining servile feminine role models or whether the school itself maintained a more traditional ethos than the London teaching hospitals - a reverse form of snobbery.

Unlike SA and J, SC did not have parents who were already upwardly mobile themselves. Like many working-class children in the 1950s, she attended a neighbourhood 'modern' school. From there at the age of fifteen she took a two year pre-nursing course run in association with the local municipal hospital, and then went on to work as a nursing cadet, finally training in the same place. Nonetheless, if it had not been for her father's persistence, SC would not have realised her nursing

ambitions because of her height:

‘My father was quite cross; his attitude was to dismiss the officialdom...Florence Nightingale was less than five foot tall...so he sat down and wrote to the local education authority saying that if his daughter wanted to be a nurse, her height shouldn’t be a reason to stop her’.

For SC, becoming a nurse was charged with the magnetism of middle-classness; she describes her nursing ambitions as a mixture of fascination and aspiration - fascination with the trappings of authority that nursing carried, and an aspiration to attain the middle-class lifestyle it seemed to promise. She recalls how she avidly read **The Lady** in an attempt to learn about the mores and values of middle-class femininity. SA’s testimony struck strong chords with my own memories, where voice training, learning about art and literature and changing our style of dress had been integral to a self improvement programme designed by my flatmates and I to address our inferiority as nursing students on the periphery of a middle-class university student body.

SA experienced quite a different trajectory to SC; she passed the ‘eleven plus’ examination and became one of the first scholarship girls to enter the local grammar school. She remembers her first encounter with class difference was at this school, where her best friend was barred from speaking to her own mother because she was a dinner lady, ‘and it wasn’t done to speak to people like that’. An avid reader of the **Sue Barton** books, SA nonetheless feels it unlikely they had any impact on her decision to become a nurse. The nursing image SA had at the forefront of her mind during the interview was based on hospital admission as a child; the image is one of



strict authoritarian femininity with very tall, very straight laced, stern women caring for her. She became a nurse largely because of a lack of other available career options:

‘I really think it was just an acceptable thing to do...I didn’t really want to be a nurse, not initially anyway...I wanted to go to university, but I was told I wasn’t brainy enough which was possibly true’.

When it finally came to choosing what to do, SA claims she didn’t really think about it very much; nursing was just an accepted career choice. She went to visit a distant relative who was a Sister Tutor at the local county hospital armed with a bundle of prospectus’ from the different London hospitals and was told to pick the one with the uniform she liked the best and apply. She remembers that the pamphlets were quite glossy and all featured pictures of nurses in heeled shoes. Her mother’s relatives, many of whom had spent their lives in service as ladies maids and nannies in various big houses, all approved of her choice of career, but, like her father, only because she had been accepted by a London teaching hospital.

To sum up at this point, most women who clearly remembered an early image of nursing associated it with their own experiences of sickness, relative’s experiences of sickness, or female relatives who worked as nurses in one form or another. These memories emphasise the more practical dimensions of women’s lived experiences, and dismiss notions of romantic vocationalism instilled by popular images and stories. Ly was influenced by her godmother who was a midwife, V by friends who were nurses, M by caring for an elderly relative, MS’s mother was a Sister with ambitions for her daughter’s future. Only two people claimed they had always wanted to be

nurses; only one thought that she had been born to it, that nursing was 'innate'.

On the whole, nursing was initially seen as a job by most of the interviewees rather than as a career. Of the two women who claimed that they had always wanted to be nurses, one of those thought that this was due to a lack of alternative role models. For some, nursing was a preferable option to working in a factory or an office or a bank. Those that had some image of what it would be like to be a nurse tended to have personally experienced nursing care, or had nursed relatives or knew relatives or friends who were nurses. Only two people remembered seeing any recruitment literature; only one person remembered reading a nursing career novel. Other popular images, such as films, early television programmes, medical romances and magazine stories seemed to have had little impact on the memories of any of the interviewees.

### **Drumming it into you : the battleaxes**

In a detailed participant observation study of professional assimilation, Kath Melia calls attention to the way that the student nurses she studied consciously 'fitted in' to the ward environment in order to get by (Melia 1987). The following accounts reveal a similar strategy, with trainees attempting to 'fit in' to a militaristic, matriarchal nursing structure which was common throughout the hospital system at the time of nursing's incorporation into the NHS in spite of historical differences at the institutional level. Although there were variations in the training programmes on offer, a quasi military structure of discipline permeated the organisation of nursing throughout the hospital system. The rigidity of this structure maintained a system

where ward Sister had a reasonable degree of autonomy, and often remained in post for most of their working lives. Images of nurses as either the handmaidens of doctors or self-sacrificing angels are most inappropriate when applied to this group. The two images that stand out in relation to the Sisters are the vocational ideal of a kindly but bossy motherly figure and the military impression of a rather cold, authoritarian matriarch. Nightingale's rhetorical concepts take on flesh and blood form in the 'battleaxe' Sister, an image that cropped up repeatedly in all of the interviews.

The 'battleaxe' is most typically a middle-aged spinster who has worked as a Sister on the same ward for many years, and runs it with the efficiency of a military campaign:

'I was very, very young and very naive...and there was this battleaxe of a ward Sister who ran the ward like a military operation' (J).

'The Sisters would put the fear of God into you...the old regimental ones used to put the fear of God into you' (Ly).

'She (the Sister) always liked to be shouting at you... she's more or less like a sergeant major, yeh? (V).

Or she might be the Sister Tutor, in charge of the trainee nurses:

'If the Sister Tutor was coming you would, you know, stand at attention and all this. Sister Tutor was real cruel looking, she was strict looking and we were scared of her' (G).

Sometimes, a younger Sister fitted the stereotype,

'Some of the Sisters mortified some of the nurses...there was no need to make

them feel like that. I hated the Sister on Clitheroe Ward, I think everybody did. She was young but she was cruel. I thought how can you be so cruel, we were so frightened' (O).

Although 'battleaxes' could be frightening, they are also remembered for their clarity of judgement, their kindness and their professional skills:

'Most of the best ones were battleaxes, they were really good, cared for their patients, nobody was ever overlooked or neglected. They had always worked there, you made your career out of being a ward Sister didn't you. With the ones who ran their regimes you knew exactly where you were' (J).

'She was the ward Sister when I first went there, a very fierce sort of person but very kindly; the balance was there and you felt very safe with her' (S).

This feeling of safety was clearly a vital one in terms of giving trainee nurses the confidence to be able to carry out their work. 'Battleaxes' who were well organised, ran their wards calmly and efficiently and were kind to the patients, are on the whole remembered fondly; on the other hand,

'there were some really awful people, it seemed no matter what you did you couldn't win, very sadistic' (SC).

The image of the 'battleaxe' is a potent one; the ward Sisters and Sister Tutors were role models for young trainees; as J comments,

'It wasn't that I was impressed with them, but it was persuasive, you couldn't ignore these people'.

SC thinks that the training approach was basically paternalistic, in that the Sisters not only looked after their charges but tried to model them to fit their own ideals.

The hierarchical relationships and the enforced discipline of hospital life left some nurses feeling disaffected. Instead of feeling empowered by the training process, they felt undermined by it,

‘People were constantly knocking you down all the time...they seemed to want to discourage any feelings of individual strength...the hierarchy was very much in evidence, and you were seen to be low down...the attitude seemed to be that we had to do this and get on with it, we had it hard, so you’ll have it hard too. I got that feeling a lot during my training’ (Ju).

In some cases, this ‘toughening up’ process had the opposite effects to what was intended. Some trainees, like Dickens, gave up their training and left nursing. Others vowed they would be different, and make changes for the better:

‘I honestly thought when I get to the top I shall be kinder, I would never want to put anybody through what I went through, never’ (O).

The interviewees’ strongest collective memory was undoubtedly that of the battleaxe; these nurses were both respected and feared, fondly remembered as well as mocked. At best, they could be supportive and reassuring, at worst they could cruelly demolish a trainee nurse’s fragile sense of self.

Images of ‘battleaxes’ have been potent in popular nursing fictions, ranging from comedic figures such as Hattie Jacques in **Carry on Matron** to sadistic figures like Nurse Rachet in **One Flew Over the Cuckoos Nest**. Few of the images are complimentary; career nurses, on the whole, were not kindly constructed throughout this period, perhaps because of more general trends to discredit career women in the public imagination (see for instance Haskell 1974, Wilson, 1980). Nurses themselves

are more ambivalent about their relationship with authority figures; what seems to have provoked the most discontent is not so much being subjected to discipline, but being made to feel an inferior and incompetent member of a rigid hierarchy. As one interviewee put it, 'they seemed to want to discourage any feelings of individual strength' (Ju). Most of the interviewees felt that they were actively discouraged from questioning things, from using their initiative, 'it was drilled out of us' (Ju).

In her autobiography, Markham (1975) describes every aspect of hospital life as deeply pervaded by this sense of hierarchy. Speaking to the medical staff, yet alone fraternising with them was completely out of the question for anyone below the rank of Sister, and she dismisses doctor/nurse romance novels as pure fiction. Trainee and auxiliary nurses claim similar experiences of subservience - to doctors, other nursing staff, para-medical staff and domestic staff.

'If you were a greybelt (first year) you were actually not only bottom of the nursing pile but at the bottom of every other pile that was going as well' (J).

'You were treated just like you didn't exist, left with all the mess to clear up, never thanked, never asked, always told...' (Ju).

The romanticised 'handmaiden' image of nursing is one that these interviewees reacted strongly against. No-one denied that the image existed, only that:

'nurse and doctor story books painted a completely different image ...I suppose they could make it up to seem ever so romantic and nice...it is not that way in reality' (M).

S felt that 'it was a load of old rubbish, it made me decide not to marry a doctor very early on, they were the biggest rogues'.

Markham's account is interesting for its descriptions of the rigours of nursing life at this time; the lack of disposable goods and equipment taken for granted today, such as toilet paper and tissues, certainly made the work dirtier, more menial, and more arduous. Her graphic accounts of clearing up faeces and other human emissions and the descriptions of her reactions to this dirty work fill a missing gap in nursing's official history. After describing in some detail the emptying and cleaning of the sputum mugs, she comments, 'Even now, I clench my teeth and keep a firm grip on my stomach when I recall that 'plop' as they emptied' (1975: 149).

Many of the interviewees undertaking general training felt that in some ways they were badly abused, asked to take on far too much responsibility before they had sufficient experience and training, 'the feeling of being responsible really was a lot, I think it was too much too early' (Ju). In addition, all trainees had to do their share of the dirty work; 'We were treated like skivvies, it was easier to give the job to me, I had to do a lot of unpleasant things' (MS). Ly recalls that she was frightened about a number of things during training but 'there wasn't much support for nurses at all, people were very hard and cold...'. Coping alone on the ward on night duty, or with just one other junior nurse was a common experience; 'night duty was always quite stressful...we were put in charge of a ward quite early (in our training) because of staff shortages' (Ju). 'We didn't realise what kind of responsibility we were taking on and we'd just do it' (Ly).

These feelings were closely connected with fears about facing death, and coping with the bodies of others. Individuals had different reactions to the practicalities of

nursing work that ranged from dealing with personal feelings of disgust (that the work was in some way beneath them) to coping with the paraphernalia of surgical and medical intervention (drains, drips, irrigations, suction etc.). Ju sums up these feelings fairly succinctly;

‘I remember being terrified a lot of times when I was training. Even doing a bed bath at the beginning was quite scary, I mean you’re 18 years old and you haven’t dealt with other people’s bodies...and they’re depending on you in a way that is completely new to you’.

In spite of their criticisms of undergoing training in the ‘old school’ however, most of the interviewees had reservations about recent modernisations. Although authoritarian hierarchies pervaded early nursing life without exception, suffusing both public duty on the wards and private life in the nursing home, the rule bound framework created a feeling of security, particularly for someone arriving in England from elsewhere.

‘It was very secure and protective really, we didn’t even need to go outside the hospital; they looked after the nurses very well, better than what we do today’ (O).

At the age of 17, SC was made a ward of matron when her parents emigrated to Canada:

‘As a cadet nurse we were protected if you like so that they could keep an eye on these tender young girls. I suppose it was a paternalistic approach, I mean if they looked after us, we came up with the goods’.

The closed and regulated life did have some compensations, primarily the enduring



friendships that developed out of a sense of shared adversity and common fears amongst those in your 'set'. A 'set' was a group of trainees who began their training together. Nursing's rigid hierarchy demarcated the various stages of training each 'set' had reached by various symbols of increased authority, usually in the form of stripes, belts or dress colour. Any fraternisation between different 'sets' tended to be actively discouraged; as a result, 'sets' formed strong friendship bonds which acted as a support network:

'when you went off duty, everybody was in the same boat, we always knew there was somebody there...' (O).

'I had a very close group of friends, people tended to cluster in groups...there wasn't much mixing outside of one's own group. Out of the 46 that started, there's still 36 of us that keep in contact regularly and we meet up every other year. We were a terribly cohesive group' (J).

'We made friends then, and we're still friends now. What I'd do without my best mate, I don't know' (SA).

On the other hand, the long hours of work and shift systems tended to mitigate against a healthy social life, creating an insular lifestyle. Living and working with nurses tended, as Dickens noted in the 'forties, not to make people very outgoing or independent. It was a tight knit, closed community. MS sums up a general feeling amongst all the interviewees when she comments,

'I wouldn't have survived without my peers...we were kind to each other weren't we'.

All the interviewees have remained in contact with at least one or two people that they trained with, a testimony to the strength of the friendship bonds forged between

those who shared the demanding experience of becoming nurses .

**Part 4. In a strange place:**  
**re-location, whiteness and the other.**

The experiences of those who came to Britain to train as nurses to train and work as nurses in the 1950s and 'sixties are still deeply hidden in the margins of other narratives, other discourses. The earliest image of a Black nurse in a British film is in **Sapphire** (GB 1959), a 'social problem' film that attempts to tackle racist issues; the nurse has a tiny, walk on role and a middle-class English accent. In the doctor nurse romance literature, the earliest image I found is in Bess Norton's **Night Duty at Dukes** (1960). Here the Black nurse Theo is given a thoroughly white middle-class identity, emphasised by her ambition to marry a white, middle-class man. It is not until the televising of **Angels** in the mid 1970s that Black nurses begin to feature more prominently as characters in fictional dramas, although Peter Nicols' biting satirical film **The National Health or Nurse Norton's Affair** (1973) has a Black nurse as one of the central characters of narrative agency.

Similarly, there are no published autobiographical works recently written by Black nurses working in Britain, although researchers Bryan, Datzie and Scafe (1985) have recorded and compiled an oral history of Black women's lives in Britain which features two accounts by nurses. Torkington (1985) and Baxter (1989) have counteracted institutionally racist accounts of Black women's experiences in the health services through researching personal accounts of their working lives. These works re-locate Black women as the subjects of their own discourse, rather than as the

objects of white speculation and interpretation.

Nonetheless, the loss of specificity across a range of representations and discourses continues to deny Black nurses voices of their own and a secure place in nursing history, even though it is estimated that by the end of the 1960s they formed approximately twenty-five percent of the nursing labour force (Stones 1972). In spite of their continuing contribution towards the maintenance of the hospital system, for the most part Black nurses are still officially unacknowledged. In contrast, white male nurses (a much smaller group of less than ten percent) are officially recognised as a minority within nursing in need of special career incentives and support.

On the odd occasion when the presence of Black nursing staff has been officially recognised, it has tended to situate these nurses as 'problems', people who could not 'fit in' to the hospital system. In her review of the literature on recruitment and attrition, MacGuire found only one study that researched Black nurses' experiences of their training. The researcher concluded that cultural differences were the primary cause of disaffiliation by Black nurses, and that they had difficulty in assimilating hospital routine as well as adjusting to life in Britain more generally (Martin, 1965). This seems to be a deliberate (mis)interpretation of the research data. MacGuire points out that all the evidence from this study indicates that once Black entrants had achieved state enrollment, they left their training hospitals to take up jobs in other sectors of the health service where there were more opportunities to further their careers by upgrading their qualifications (MacGuire 1969: 186). This can hardly constitute a failure to 'assimilate hospital routine', or problems of adaptation to life

in Britain; rather a determined effort on behalf of the individuals concerned to continue to try and fulfil their unmet expectations.

As Ly commented in conversation after her interview, the main problem that Black nurses have had to face in England is being seen differently, being seen as outsiders. One of the problems this group has about their image of nursing is that until recently both public and professional images of Black nursing identity in Britain were very marginalised, and as a result not available to people. Once people arrived in Britain, they were confronted with white images of nursing which projected a similar discourse of nursing values to that promoted in Barbados, but whereas the latter had been the focus of aspiration, the white image was disorientating. Ly's memory of the image of her godmother has helped to keep alive her belief in her innate ability to nurse, against the problems of struggling to achieve her ambitions in institutions dominated by the ideologies of whiteness.

In **Behind the Screens**, Jocelyn Lawler discusses at some length how female nurses manage the problem of unbridled male sexuality when they are intimately caring for male patients. Lawler considers that male patients sometimes act in this way because 'sexuality is a pervasive aspect of social life and almost any situation is a potential occasion for sexual expression' (Lawler 1991: 213). Arguably, in British society, racism is also a pervasive aspect of social life, and almost any occasion can provide the potential for the expression of racial prejudice and hatred. Black nurses have to manage situations at work where both patients and colleagues of either sex can react in relation to their 'Blackness'. In this respect, all the nurses interviewed here found

‘managing’ their white nursing peers and hospital management teams far more difficult than managing racist reactions from their patients.

Other sections of this chapter bury the specificity of Black experiences within general accounts of the image of the ministering angel, the battleaxe and the sexy nurse. These images present problems for Black nurses that are not immediately obvious; for example, the image of the battleaxe was a recurring one in their accounts, as it was for most of the white nurses but whereas for white nurses the battleaxe represents a history of class based military authority, for Black nurses it continues to resonate with an image of white oppression and colonial rule. (See Poovey 1989 for a detailed account of the connection between Nightingale’s use of the military and maternal metaphors and colonisation.) Several of the interviewees point out the absence of Black nurses in positions of power and responsibility in English hospitals compared with their concentration in the lower grades of the least prestigious areas of nursing such as geriatrics and psychiatric care. As I pointed out in Chapter 3, where the prestige attached to cure is low and care is viewed as curatorial or custodial, nursing has traditionally tended to be organised on a task centred basis that isolates the most physically demanding and the dirtiest jobs. This hierarchical care structure reinforces notions about the low status of geriatric nursing in the profession, a status that is reflected in the salary scales and ‘glass ceilings’ on professional progress. The nurses interviewed here point out how their ethnicity and gender has trapped them in the lower staffing grades in the lowest status areas of the nursing profession.

The historian Carolyn Steedman claims that: ‘Personal interpretations of past time -

the stories people tell themselves in order to explain how they got to the place they currently inhabit - are often in deep and ambiguous conflict with the official interpretative devices of a culture' (Steedman 1986: 6). This is particularly true of the stories told by the group of women interviewed here, whose systems of beliefs and values are deeply immersed in the official discourses and ideologies of professional nursing but who nonetheless find themselves excluded from that discourse and denied a voice or a place from which they can speak. The accounts that follow were told to me by four women who came from Barbados to train as nurses in English hospitals between the early 1950s and the late 1960s. Their desire to tell their stories was strong, even though there was an awareness that they would inevitably be mediated through the official interpretative device of my (white) doctoral study. The stories have been told on the understanding that one day they might contribute to a history of Black nurses lives in Britain written by a Black nursing scholar. In honour of that understanding, transcripts of the interviews and copies of the tapes are included as an appendix to this thesis. The original tapes will be lodged in the National Sound Archive.

In the synopsis of their accounts which follows, the mediating frameworks I have used in order to present the interviews are important interpretive considerations. First of all, I decided before I began the interviewing process that I would use the same questions for all the participants as a basic framework for discussion and that I would avoid asking 'leading' questions, particularly on issues of difference. In theory, I thought this would leave individuals free to steer a course through the interview without feeling too directed by my assessment of what the important issues were. In

practice, two interviewees made it clear to me before we began that they wanted to talk about racial issues in nursing.

Secondly, the problems inherent in any transcription process from oral to written form are compounded if the interviewer and interviewee do not share a common cultural background. This is a particularly important issue, given that 'otherness' to nursing's white middle-class ideal has invariably been presented in fictional texts through the use of different speech idioms in the form of heavy accents and dialects. In the **Sue Barton** books for example, accent is used as a metonym for outsider status in society; the 'waif' Marianne who Sue 'saves' from a life on the streets of New York is represented as heavily accented in the initial stories but as she gradually assimilates a white middle-class identity, her guttural accent disappears. On the other hand, straightforward assimilation into the white middle-class ideal (as in **Night Duty at Dukes**) denies Theo, who is from Jamaica, any pleasure or pride in her own cultural identity. Although nobody amongst the interview group singled out accent and dialect as a problem, it is clearly an important aspect of the differential power relations inscribed in the processes of mediation and interpretation. Hence, the tapes and transcripts are provided to enable secondary revision and analysis.

What follows is my understanding of the stories which, for clarity of analysis, I have summarised and divided into three sections. These outline different stages of engagement with nursing ideals and practices. In the first section people discuss their earliest memories of images of nursing, most of which centre on their experiences as children and young women in Barbados. The positive image of themselves as nurses



held by this group comes from their early memories of nursing, and its status in Barbados as a highly regarded profession for women. In the second section, the focus switches to memories of emigration and arriving at hospitals in England to begin their training. There is a keen sense of displacement and vivid images of a quasi-military style discipline which was sometimes experienced as demeaning. The third section concentrates on the more recent past and a growing sense of disaffiliation from the National Health Service and the nursing profession as years of dedicated work and service have been ignored and unrewarded.

Throughout this section, the interviewees throw some light onto the question of what happens to self image when dominant discourses do not correspond to lived experience, when the gap between the self as an image and the public image of that self seems to grow ever more unbridgeable. The sense of outrage felt by the interviewees is not directed at nursing's ideal conception of itself, but at the institution of nursing in Britain, and the National Health Service. The latter in particular is viewed as the villain of the piece for refusing to tackle the racist ideologies inherent within its system of institutional care.

### **Early images.**

Early images of nursing tend to have come from female friends and relatives at home in Barbados, some of whom were nurses themselves, some of whom wanted their daughters to be nurses. Playing games pretending to be nurses and doctors was quite popular. Three people had wanted to be nurses from when they were quite young.

Ly was most influenced by her godmother who was a midwife:

‘She was a very bubbly and loving type of person so she would always come around and see you from time to time and I would see her walk in with this crisp white apron and a little like straw basket over her arm and just go round the village visiting people’.

Some people had vague memories of reading books about nursing, but thought that they had not been at all influenced by popular stories and magazines. One person remembered reading doctor nurse romances, which ‘painted a completely different image in the book than what in reality it is’ (M).

Amongst this very small group, there seems to be little apparent difference to me between their early images, hopes and aspirations and those of some of the white interviewees. In Barbados nursing was viewed as a relatively high status occupation for women; the image of nursing seems to have had a great deal in common with that projected by the London teaching hospitals, promoting personal qualities of patience, self sacrifice and service to a higher ideal. It was a difficult profession to enter with limited opportunities for training:

‘The nurses there...they were proud. They were proud girls to be nurses. Anybody who got into the nursing profession there were more or less respected and they were proud’ (M).

When opportunities opened up for training in Britain, for some it seemed to offer a chance of realising aspirations which might otherwise have remained unfulfilled at home. To train as a nurse in Barbados, you needed to come from quite a wealthy family; for young upwardly aspirant Barbadian women, the opportunity of training

as a nurse in Britain seemed an ideal way to achieve a coveted ambition.

### **Recruitment and training**

There is no doubt that these personal aspirations were the embers of ambition fanned by recruiters to persuade young women to leave their homes and train in Britain, although the actual mechanisms of the recruitment process are only partially revealed in the accounts below. People came to nurse in Britain through a range of different routes. V was given a copy of a British nursing journal, the **Nursing Mirror**, by a friend; she wrote and applied to three hospitals in the south of England, all of whom accepted her. Rather than going through the formalities of government sponsorship, her parents paid her travelling costs. G and her friends responded to a government led recruitment drive. She remembers hearing about it on the radio, and through the careers service at school. Ly arrived in England to join her mother, a nursing auxiliary, when she was almost fifteen. She decided that she would become a nurse, and applied for training at a local hospital as soon as she was sixteen. M came to England to join her boyfriend, writing to several hospitals in the hope of starting her training, but she was unsuccessful. She married, had her children and then began working as a nursing auxiliary in the early 'seventies.

Many people seem to have been unaware that there were two forms of nurse training available in Britain. In Barbados, only training for state registration (general nursing) was available, and only state registered nurses were employed, therefore becoming an enrolled nurse was not useful for anyone wanting to return home. G claims that decisions about who did what training were made in a fairly arbitrary way by

Barbadian government employees:

‘A lot of us didn’t know until we got here. They never let us know over there. And they used to decide - favouritism I guess - who they sent to do enrolled nursing and who they sent to do the General’ (G).

G claims that a lot of people ended up in her situation, spending two years training for the roll, who had sufficient educational qualifications for general training. Because she was on contract to the hospital, she had no option other than to complete the two years and get her certificate before she could start her general training, ‘I was determined that as soon as I finished, I was going to do my general’. Enrolled nurses had to go back on student pay whilst general training, and were only allowed 6 months off the three year training period for their existing qualifications. This was an added disincentive to take up training for nurses like V who had to support their families, whether they were living in Britain or, as was sometimes the case, at home in Barbados:

‘After a few months I was thinking about doing my training but the pay you got was so small I couldn’t afford to do my training then...the wages at the end of the month are only eight or nine pounds...’.

V shared a room with two other women in a similar situation to herself who had to send money home for the care of their children, and as a result of this could not afford to give up their auxiliary nursing jobs to train.

Some people commented on the fear and strangeness they felt when they arrived in Britain. G remembers how she didn’t like England when she arrived in 1961, and how strange she felt ‘because everybody was white’. In conversation after the

interview, V told me that she felt as if she was going to be eaten alive by white people when she got off the boat, but that going to the hospital offered a sense of some security. Both V and G started work almost immediately after their arrival at the hospital, only a day or two after they had arrived in England. Although she was wearing the coveted nurses uniform V initially found the work distasteful, she had not expected to be dealing with so many elderly, incontinent people. G found herself in a small country hospital working with eight other Black nurses; looking back now she thinks she was lucky going to Yorkshire because people were very friendly.

One of the significant differences between the training experiences of Black and white nurses lies in their social lives. The white nurses recalled how their social lives had revolved around their own cohort groups, and that they rarely mixed with those outside their own set. The positive side of this was the strong bonds forged between women which have been carried into their later lives. Black nurses tended to ignore the peer group hierarchy, bonding across sets and national boundaries to form networks of support:

‘I felt strange but it was nice because...there was eight other Black girls there.

As soon as they heard the new ones were in they came to introduce themselves. And they were around to let us feel at home. But we were very homesick’ (G).

Ly remembers having a healthy social life:

‘There were girls from Jamaica, Trinidad, Bermuda, and there were lots of colleagues from Mauritius and lots from the Caribbean Islands so it was quite interesting’.

In addition, there were staff in the hospital kitchens from Greece, Spain and Italy. V remembers a good atmosphere, taking turns in off-duty time to cook food to share with the others, courtesy of a local butcher who used to provide cheap meat for the nursing staff.

Experiences of training were in some ways similar to those of white nurses; people recounted similar stories about their place in nursing's hierarchy, with authoritarian sisters and autocratic medical staff figuring in similar ways. V remembers learning many of her basic nursing skills from one sister in particular, who made no distinction between what she taught to auxiliaries and pupil nurses. G, at a hospital in Yorkshire in the early 'sixties found the people warm and friendly even though the sisters were somewhat daunting. V remembers one sister who always picked on Black nurses, 'she always liked to be shouting at you' but on the whole remembering being treated with respect. M found herself working with a nursing officer who always found fault with the Black nurses, rarely with the white.

'I know I'm an auxiliary, I know I'm lower down the scale, but she made me feel so...oh...she wasn't nice at all.'

Working with somebody who was determined to find fault was clearly an undermining experience during the early days of training/ working, but for this group of women it was the nurses re-grading exercise in the mid 'eighties that finally undermined them after many years of coping with day to day racial harassment. This issue informs the final section of this part of the chapter.

### **Reflections on a life in nursing**

This group of women had to cope not only with the disappointments of arriving in Britain and finding it a very different place to the idealised conceptions of the 'mother country' they had been taught to expect at school, but with working in a system of health care that fell well below their expectations. M pointed out how the British system of caring for the elderly in old fashioned and poorly equipped geriatric hospitals seemed quite uncivilized compared with Barbadian standards;

'It was shocking at the beginning. They thought that we - West Indians were primitive, but when I came to the hospital it was more primitive than what we had...'

M recalls that at that time,

'nobody wanted to work in geriatrics, nobody. I think they wanted people coming to England to work on geriatrics'.

M worked with two SENs caring for 52 elderly people on two wards whilst she taught her basic nursing care; she remained in geriatric nursing for eighteen years. A particular milestone for the large black workforce in geriatric nursing was the move for unionisation in 1974/5:

'We had a coloured bloke who came working at the hospital, and he was in charge nurse and he started up the union. Well, there might have been a union before, but nobody came to us...And it was only when the union came along that the staff began to increase...' (M).

Like the other women interviewed here, M has steered her daughter away from a career in nursing; she feels that the changes in the NHS are making things worse for

nurses, who are being asked to work more hours for the same pay.

‘They haven’t said anything about redundancy yet, but what has come up now they given us part-timers - I work thirty hours a week - this is what I understand it to be, that every nineteen weeks we work one night without pay.’

The sense of outrage felt by M at the low value placed on her years of hard work and commitment to the NHS is echoed by the other interviewees. Ly now works as a staff nurse on a surgical ward after sixteen years on night duty in a special care baby unit. Commenting on the fact that foreign nurses were placed mainly on the geriatric wards, Ly felt that the price paid for this was that they gained only limited experience of medical and surgical nursing, which made it difficult for them to move from the geriatric wards. Ly sees the nurses re-grading exercise in the mid 'eighties as something of a victory for those working in this traditionally undervalued area of nursing because SENs were finally given recognition for running wards and being responsible for large numbers of elderly ill patients. Apart from this small victory for the large Black workforce in this area, she thinks it is very hard for a Black nurse to move up the career ladder; white nurses dominate nursing management out of all proportion to their numbers overall.

‘I think really that Black nurses realised that this was happening and that they weren’t getting anywhere fast and they opted out. I notice that there aren’t as many in nursing’.

Ly is deeply frustrated that in spite of achieving state registration and taking extra courses, she has been unable to fulfil her aspirations in nursing;

‘I’m the last person to have a chip on my shoulder, but it does seem that once



you're Black it's ten times harder to move'.

She thinks that nursing is less attractive as a career for women these days unless they want to move into management or specialise in an off-shoot area like health promotion. At present, her twelve year old daughter has ambitions to be a lawyer.

V has spent most of her working life as an auxiliary nurse and is now looking forward to retirement. In spite of all her years of experience of caring for elderly patients, she has to carry out the instructions of student nurses who are still at college and have very little experience on the wards. Her skills and knowledge are ignored, making her feel undervalued and regretful that she didn't do her training:

'you get some young little staff that just come out, (of college) maybe I was a nurse before they were born, and, oh, want to push you around, and makes me feel sad.'

V thinks that they're 'trying to do nursing by paper' and that nurses no longer provide the levels of physical care that they used to, even though there are more staff on the wards.

'Sometimes you go to the ward, you can't get a cake of soap, there's no dettol, there's no savlon...it's awful. Now the patients can't even get a slice of bread. There's no breakfast coming out, no bacon or eggs and I think it's wrong for the old people because they have worked all of their years and at the end of their life, they should get treated better...'

G worked as a sister on a gynaecological ward for twelve years, and is now having a rest from the National Health Service, which she thinks has become a deeply racist

institution. Although she agrees that the nurses' re-grading exercise did benefit some Black nurses, it was also used to discriminate against them. G was the senior Sister on her ward by many years, but she was given a lower grading (and hence a lower salary) than her white co-worker. Her tribunal appeal was never heard. As the cuts in health services started to be severely felt at ward level, morale amongst the nursing staff fell and tensions between the staff grew. G decided to take early retirement whilst she was still young enough to get another job. She can provide numerous examples of the poor treatment Black nursing staff received during re-grading at her hospital and the preferential treatment shown to whites.

G is also highly critical of government policy and the effects that the new internal market in health care services is having at the level of day to day management of patient care:

'Patients were complaining that their food was shocking, and the wards weren't clean because they'd cut back on cleaning and domestic staff...they expected one person to do the work that three people used to do. Impossible'.

Her views on the changes in the education and training of nurses are similar to others in this study; that college and degree level trainings do not equip nurses properly with the skills they need to be able to do their job. Like the other women here, she would not be keen for her daughter to take up nursing in the health service.

This short study therefore entirely supports Baxter's thesis, that the Black nurse is an endangered species unless the health service can prove to those who remain that the change towards a privatised model of health care is a change that will value the

contribution of Black nurses. To date, this has not been shown to be the case.

The problems of subsuming the experiences of all female nurses under a generalist rubric are clear. The social histories of nursing need to include the contributions that Black nurses have made to the profession, and the difficulties that they have had to overcome. As a profession that has been shaped by issues of class, status and gender rather than the possession of a particular, specialist body of scientific knowledge, professional nursing has always been torn between striving for status through education and training, and trying to achieve it by proving their managerial ability through control of the (largely) female workforce who do nursing work. Both of these projects involve one group of people subjugating an other. Achieving recognition in the profession has tended to mean specialising in either education or management, leaving those who wished to develop their practical expertise in caring skills without a clear career path once they obtained their registration.

This hierarchical structure was a particularly invidious one for those arriving to train as nurses from Britain's former colonies. Not only did they end up working in the least prestigious areas of the health service such as geriatrics and psychiatry which have always been notoriously underfunded and understaffed, but once there, they were caught in a financial trap. For many Black nurses, their ambitions to enter the profession as registered nurses ended, cruelly squashed by a combination of low pay, low status and long hours of hard and dirty work.

In an analysis of the racial division of reproductive labour in the United States,

Evelyn Nakano Glenn points out that 'race' has tended to be analysed in academic feminism as an additional oppression to that of class, rather than as integrated element of class and gender exploitation. Glenn argues that in the first half of this century, racial-ethnic women were employed as servants in white households to relieve middle-class women of the more onerous aspects of reproductive labour. With the expansion of the commodified service sector in the second half of the century, racial-ethnic women are disproportionately employed in lower level service work, whilst white women filled the cleaner, white collar supervisory and lower professional positions. The division of labour in the household is mirrored by the division of labour in the public sphere, where racial-ethnic women are employed to do the unseen and heavy, dirty servicing work such as cooking, cleaning and caring for the elderly and the chronic sick. Glenn argues that with the shift of domestic labour from the private to the public sphere, a face to face hierarchy has been replaced by a structural hierarchy. She illustrates her points using a study of stratification in the nursing labour force, pointing out how white RNs (the equivalent of state registered general nurses in Britain) are over-represented in the top grades in relation to nursing numbers overall, whilst racial-ethnic women are disproportionately represented in the lower grades of nurses' aid (the equivalent of an auxiliary).

In Britain, as Stones (1972) has pointed out, Black male and female nurses were often employed in low status specialist areas such as psychiatry where male nurses were traditionally employed. In terms of Williams (1978) model, Black nurses were placed in positions of custodial care, with the underlying implication that Black female nurses were seen as not only 'closer to nature' than their white counterparts, but also

as relatively masculinised. The barriers to their progress, although ostensibly presented as educational and cultural, were essentially those of professional nursing's ideal of white middle-class femininity. But the national health service increasingly relied on the low paid labour of Black women (and some men) to sustain and maintain a system of state welfare provision that promised care to white Britons from 'the cradle to the grave'. To meet the provisions of this social contract, Black labour was imported from the former British 'colonies' under the auspices of 'training' and 'aid'. Many of those who came to Britain believed that they would be able to train as nurses, and return home. Instead, they found themselves trapped by contracts, low wages, and non-viable qualifications with no means of redress. In this way, they continued to be subservient to the power that had colonised them, doing the dirty work on which a more 'caring' society was being built.

Institutional structures buffer and mediate the relationship between those who do the dirty work and those who benefit from that work. The institutional care of, for example, elderly white people by Black nurses clearly benefits white women, who would otherwise have to shoulder this burden of reproductive labour. In Britain, this burden was traditionally carried by women from the lower social classes and Irish immigrant labour who formed the bulk of the nursing staff in the former workhouses and municipal hospitals. When there was insufficient local labour to staff these institutions, nursing managers 'sent for a boatload from Barbados' (Rose, personal communication 1992) to make good the shortfall. As White (1985) has pointed out, successful management was judged in terms of ensuring there was a constant supply of labour to meet the demands of care. In this institutional hierarchy, class, gender

and race became an intertwining nexus of personal determinants that shaped the lives and careers of Black women in British nursing.

## Part 5

### Self as image, image as self: the ‘proper’ nurse.

*‘For those who survive the basic training course, personal identity is inextricably bound up with identity as a nurse’*

(MacGuire 1969: 107).

Rather than ending the chapter with a conclusion, I want to broaden the discussion and address two concerns emerging from the thesis which lie at the heart of images of the self as a female nurse. The first of these is an individual’s mental image of the ‘ideal nurse’, what she considers a ‘proper’ nurse is or should be for those involved in nursing practice; the second is the relationship of these images to the official discourses of nursing that have constructed them. In this final section of the chapter, interpretations of the past are placed in the context of the present. In part 1, I discussed the role played by narrative in accounts of the past. In this section, I return to the concept of the ‘ideal’ nurse discussed in Chapter 2, only this time I analyse the relationship of that ‘ideal’ to a personalised, professional sense of self existing in the present through which accounts of past time are refracted. One way of thinking about this self is as a personal ‘ideal’ or image reflected through the critical lens of every day nursing practice and honed on officially prescribed professional ideologies and institutional determinants .

### **The 'Proper' Nurse.**

The concept of the 'proper' nurse is an important one in the context of a feminist analysis of images of femininity. The 'proper nurse' is a discursive formation formed and shaped by the processes of becoming and being a nurse. It is inextricably part of each individual's self-perception, the underlying framework of beliefs and attitudes that has shaped each response to the interview questions. Each individual's conception of the 'proper nurse' is formed from a mixture of their pre-nursing histories (their backgrounds, education and early working lives as schoolgirls, hairdressers, factory, shop and office workers, nursing cadets, bank clerks), their experiences of training (in a range of hospital settings) and their current working lives (as nurses, mothers, teachers, researchers, managers, midwives, psychologists, counsellors).

Underlying the memories recounted to me of their earliest images of nursing, each interviewee has an image of what constitutes their idealised conception of the 'proper nurse', an amalgam of the principle attributes that every nurse believes to be an integral aspect of her nursing work. Foundational concepts of the 'proper' nurse are initially formed during the training process. Throughout the time of this study, elements of the Nightingale training model were still prevalent throughout the hospital system. In particular, most trainees were subjected to an intensive ethical training that constantly proclaimed service to the patient as nursing's highest ideal. The split identified by White (1986) between the different discourses of professionalisers and managers is not apparent at the level of training because training was the one area of nursing securely controlled by the professionalisers.



Amongst the interviewees, it is perhaps unsurprising that those with the most clearly discernable image of a 'proper' nurse were trained at London teaching hospitals. As one interviewee commented, 'If I meet ex-London nurses I can spot a Guys' nurse anywhere, she has this arrogance' (J). This also applies to some extent to those trained in provincial teaching hospitals, where the nurses had a tendency to view themselves as superior, 'a different calibre to everyone else' (MS). Many of the teaching hospitals promoted an ethos of superiority amongst their nursing staffs based not only on their modern reputations for medical excellence but on their traditional religious legacies of dedication to duty and devoted service. With this heritage to protect and promote, it is not surprising to find that the nursing schools attempted to instill a moral education as well as a nursing one into their new recruits. Some nurses were still having to sign a contract of moral conduct promising not to bring the name of their hospital into disrepute as recently as the mid 'seventies. All contact with members of the opposite sex was open to scrutiny by nursing management; MS remembers being called to account by a senior nursing officer for holding a dying male patient's hand because it was deemed 'unseemly'. Other interviewees commented on the restrictions that still denied all men (even fathers) access to nurses' homes by the mid 'seventies;

'you had to sign in and out, you couldn't be in after a certain time without them knowing where and what time you were coming in. It was so strict it was unbearable' (Ju).

In addition to policing the living and working environment of their trainee nurses, some institutions attempted to control their off-duty time as well. Fraternising with the medical staff in off-duty hours could earn a student a sharp rebuff from a senior.

Marriage was often seen as a form of betrayal, of placing personal desire before public duty.

Wearing the wrong kind of clothes in public could lead to professional expulsion. J remembers that

‘there was a girl in the third year who got her photograph full length in the **Daily Express** as part of an article illustrating what the modern nurse looks like and what the modern nurse has to live on. There she was in a short skirt, long boots, looking very glamorous and she was told after this that she wouldn’t pass her hospital exam...they wouldn’t allow her to work as a staff nurse at Barts’.

On duty, make-up and jewellery were forbidden, hair had to be worn above the collar and off the face, and shoes had to be ‘sensible’.

This study reflects a very strong sense of identity formed by those who trained in teaching hospitals. Whether this is due to interviewees selecting teaching hospital training because of the image these hospitals projected, or whether this ethos was absorbed during training is more difficult to determine. MS for example chose to train at a teaching hospital because she wanted to overcome her feelings of inferiority as a middle-class girl in a working-class occupation (hairdressing), whereas J. claims she would never have become a nurse at all if she hadn’t been accepted by one of the London hospitals of her choice. Social status rather than the pursuit of educational excellence was the major factor in both their choices, underlining what one interviewee called ‘the snobbishness’ of these institutions.

This study can give no indication of the degree to which any particular image of the 'proper nurse' promoted by a training institution was internalised by those becoming nurses, only that there was an awareness amongst most interviewees of what the hospital's image was. J thought she developed a very strong sense of identity because there was no gap between theory and practice,

'We did exactly what we were taught in school. I think the sense of identity was very, very forceful, you may have took it for granted at the time, but when you get a bit away from it, you realise it gave a sense of coherence too. I think we had a very strong sense of identity, the uniform, the whole thing about training in that hospital gives a very strong sense of identity, and I think a sense of identity might be quite important' (J).

Images of the 'proper' nurse amongst most of the women that I interviewed remain close to more traditional ideals of nursing excellence, debunking more modern images of the highly skilled and educated professional at ease in a high-tech medical environment. SA expressed this as follows,

'All this high tech stuff to my mind isn't nursing. An awful lot (of nurses) to my mind now don't seem to be that interested in the patient'.

This portrait of the 'proper nurse' is however not quite so traditionally vocationalist as it might at first appear. Unlike the stereotypes pictured in popular and professional discourses, the personal image is a much more complex, composite and multilayered one. Each person's early impressions of nurses and nursing have been constantly revised and renewed in the light of experience. This means that the mental concept of 'the proper nurse' contains fragments of popular and professional discourses, but

these are deeply gouged and wrought by the experiences of becoming and being a nurse. SA graphically illustrates this point when she tries to describe an incident that left a lasting impression on her;

‘I remember sitting by his bed and fighting death between us and that’s what it felt like.’

This was quickly followed by,

‘Absolutely crackers -but that’s what it felt like’,

covering any embarrassment that such a melodramatic revelation might cause to either of us within the formality of the academic interview situation. The discourse of nurses’ emotional work haunts SA’s account of her training and her concept of ‘a proper nurse’, but as I discussed in the introduction to the chapter the consistent devaluation of this kind of work as ‘tender loving care’ leaves it veiled beneath an apologetic wimple of vocationalism.

Most nurses are trained to hide their feelings and respect the privacy of others and this becomes internalised, a discursive formation that shapes the ‘proper’ nurse. In the interview situation, each person’s mental image of the ‘proper’ nurse was a projection of fragments from a range of other discourses: from their own nursing histories, from popular stereotypes and professional ideals. All of these were refracted through the lens of personal reflection to create a personal projection of the self as a nurse. One interviewee commented on how the interview process had forced her to focus on her feelings about being a nurse; the narrative she created helped her to rethink her past and draw her fragmented experiences together.

The sense of an internal construct of an ideal image comes across clearly in the autobiographical writings of Markham and Ash. In their reflections, which span lengthy periods of their working lives, both present images of the kind of work that nurses do and the satisfactions and frustrations that they experience that could easily be tagged vocational. Their discourses are however quite different, and rest on very different premises. Markham harks back to a pre-war vocationalism that places character and personality at the centre of the nursing ideal. She quotes her list of ideal attributes from a 1930s training manual (**A Complete System of Nursing**, Millicent Ashdown, 1939):

‘She must be active yet quiet and deft, methodical, reliable, careful, clean and neat, observant, intelligent, economical, possessed of self control preserving gentleness, tact, sympathy and common sense; careful to respect professional etiquette, remembering what is due to those in authority, courteous in manner, careful to wear her uniform with spotless simplicity, with tidy hair, no jewellery, her general bearing that of military smartness; careful to be guarded in her behaviour towards doctors and students’.

This image closely corresponds to Mrs Bedford Fenwick’s conception of the nurse as a woman of sound character and disposition, an ideal of white middle-class femininity. Personal initiative, patient advocacy and self-assertiveness form no part of Markham’s picture. She believes that the better pay and conditions nurses achieved as a result of their militant campaign in 1974 ran the risk of attracting ‘the wrong type’ of young woman into nursing, and that nursing is the kind of work that can only be done by young women who possess particular personality and character traits. Evelyn Glenn (1992) points out how these traits were used in 1930s North

America to prevent Black nurses from becoming part of the white professional elite. In British nursing, as I have shown, these unspoken assumptions continued to underpin recruitment policy and practice throughout the period of this study.

In contrast, Ash places initiative, self-assertiveness and patient advocacy at the core of her nursing self. Ash is concerned with how escalating bureaucratic control and rising inefficiency in the hospital system has undermined nursing morale. As a senior nursing manager with responsibility for staffing the wards, Ash became aware that trained staff were leaving the profession in droves. A lack of investment in staff, equipment and resources but a continuing reliance on nurses' goodwill and self sacrifice finally led her to take early retirement herself. Whereas Markham sees standards ebbing away as the fault of individual nurses who do not place their patients' needs at the top of their list of priorities, Ash has a greater awareness of the role played by government policy and institutional factors. Ash describes a system that is breaking down in spite of the efforts of over worked and under resourced staff to shore it up. Most of the nurses I interviewed agreed with this:

‘the communication between the patient and the nurse is not what it used to be...Now the nurses have so much paper work to do before they go off duty that they don't have time to sit down and talk to the patient’ (M).

Before she left her sister's post, G recalls that

‘Patients were complaining their food was shocking, and the wards weren't clean because they'd cut back on the domestic and cleaning staff...We all had to be mentors. We all had to be assessors. All the changes, yet you were still expected to carry on just the same’.

The strength and determination of these nurses to defend their personal image of the 'proper' nurse in the face of diminishing resources and an increasingly stressful working environment can be read as an assertive defense of personal nursing values rather than a passive, obedient acceptance of hierarchical professional authority. Although it is impossible to generalise from such a small sample as the group I have talked to, it is perhaps significant that the most vehement defenders of patient's rights in this study were those who had in various ways found themselves disenfranchised from nursing's white middle-class ideal.

The deep ambivalence that some of the interviewees felt about their sense of a 'nursing self' became apparent in their comments on education and training and nursing as a career for women. Personal insecurities about nursing's professional identity and social status have compounded with knowledge of the effects of diminishing resources on the provision of health care to create a fracturing sense of personal and professional identity. Discourses of patient centred care are out of step with managerial demands for financial control, acute staffing shortages, and statistical evaluation based on cure. This has led to a range of self protective strategies, from trying to emotionally detach oneself from the work, what Ju described as 'becoming an automaton', to a complete denial of the nursing self as in J's 'I don't identify with being a nurse anymore'.

Most of the nurses that I interviewed who were still working expressed this ambivalence about their role and their work. In spite of a very different range of experiences, there was a general feeling that standards were declining, and that they

were no longer able to deliver the kind of patient care that had given them job satisfaction. Day to day working realities and their mental concepts of the 'proper nurse' were no longer in harmony. G put it this way,

'Nursing's not the same, not in the hospitals anyway. Everything was focusing on the money',

and Ly

'Nursing isn't very different, nursing is more or less the same but I think all the changes and influence have come from the political side'.

Most people pointed to the conflict between an ideal image of patient centred care and the diminishing resources that could provide it. Several people commented that nurses used to be kinder and more loving towards one another and the patients than they are now. Ju put it this way:

'There aren't the resources there to do what you want to do, you're constantly battling to get enough time to do even the basics, and it's a losing battle. You either decide that you get out or just switch off'.

All the nurses I talked to had spent their working lives involved on the 'front line' of patient care or in management and teaching positions. Whilst most were critical of their own trainings, when asked about the new college based systems of education that students now have to undertake, there was little enthusiasm for the approach. The general view seemed to be that although the modern nurse is more willing to question and is occasionally more assertive, she is less confident in dealing with patients, and less well equipped to deal with the toil and stress of modern hospital life. Perhaps the reason for this perception of the modern nurse is based on a



generational difference of what constitutes the 'proper nurse', since younger nurses have entered the profession informed very differently by issues of funding and finance to the previous generation. As one interviewee ruefully commented, 'we're all expected to be care managers now'.

The 'proper' nurses constructed by the interviewees primarily centred on a caring image, one that is usually associated with 'bedside' nursing rather than a career in nursing management or education. Many commentators have pointed out that female nurses are reluctant to leave the bedside, that to no longer directly care for patients is felt to be tantamount to betraying the cause (see for instance Brown and Stones, 1973 and more recently Williams 1994). Most researchers point out that the primary cause of this apparent lack of ambition is the conflict that women face between maintaining a career and family life. For many nurses however, a refusal to move into management or education is not just a whimsical notion that they will be betraying the cause, or necessarily due to conflict with family life, although these might be presented as reasons for their decisions. A refusal to manage is grounded in real fears of having to institute staffing cuts, operate disciplinary procedures and maintain morale in the face of diminishing resources and falling standards of care. As resources in hospitals have shrunk, the battle for the hearts and minds of nursing staff has been fought more bitterly between nursing management and educational professionalism, with personal concepts of what might constitute the 'proper nurse' being ripped apart in the process. Whilst some might find this reconfiguration a challenge, the nurses I talked to who were still clinical practitioners at the bedside felt fragmented, disillusioned and low in morale. For others who had moved up the scale

to more senior positions in clinical practice, management and education, changes in the health care system have forced them to re-evaluate not only their personal conceptions of an ideal nursing self, but in some cases nurses' role in the health care system and the division of labour on which that role has traditionally been based.

The correlation of the 'proper nurse' with personal conceptual frameworks based on aspects of vocationalism is changing as the nursing profession attempts to re-mould itself to fit the market model in health care services. In the past, differences between the competing power groups in the profession were somewhat tenuously held together by the professionalisers control of a national training curriculum that included a heavy dose of moral education. In contrast, the modern nursing curriculum has been shaped by the academic demands of the higher education system. These changes are bound to have a deep and fundamental effect on nurse training as the current generation of trainers and managers pursue a combined approach of academic study with a less rigorous practical training programme. Changes in discourse, away from notions of 'serving the patient' to providing 'care management facilities' are indicative of a less 'hands on approach' that will increasingly place the patients in the care of untrained 'nurses aids'. These new discourses of nursing will percolate through the personal, professional and public imaginations during the next decade or so, as one generation of nursing leaders is replaced by another. It remains to be seen whether these emergent groups will succeed in re-shaping the rhetoric of 'tender loving care' that still cloaks much of nurses' work into a discourse that can give economic and intellectual value to the intimate work of caring mentally and physically for a sick person. Such a move will be necessary to ensure that high standards of nursing care

are safeguarded for the patient / clients of the future.

In the final chapter of the thesis, I examine my own nursing 'ideal' and the relationship of this 'ideal' in shaping the research design and the research process. What part has nursing training and this 'ideal' played in the re-making of the self as a feminist researcher?

My decision to undertake degree level education as a mature student was based on the knowledge that I could still earn money as a trained nurse; I knew I would be able to maintain my personal financial commitments. During the holiday periods, working as an agency nurse in Glasgow and in London, I talked to a wide range of nurses many of whom were dissatisfied, for one reason or another, with the current state of the health service and their own roles within it. I became increasingly interested by the fact that so many female nurses felt trapped, as I had done some years earlier, in a working environment which they found physically demanding, intellectually unstimulating and poorly paid. Why, I wondered, did so many women spend so much time training for a career that failed to satisfy them intellectually, financially or emotionally? Why had I?

## CHAPTER 4

### The research imagination

*'We ought to acknowledge, more honestly than we do, the extent to which our studies are reflections of our inner lives'*

(Kreiger 1991: 1).

Conducting doctoral research has an imaginative, creative aspect to it even though it is situated within academic discourses that both define and limit it. In this final section of the thesis, I want to discuss some of the factors that have shaped my research from the initial stage of project design, outline the process of doing research, and conclude with some general points that open up this area of work for further research and development.

#### Designing a Project

The emotional energy generated by my experiences as an agency nurse led me to re-think my own relationship to nursing. Why had I given up a successful career for a risky, uncertain future working in the arts that had culminated in studying for a degree in film and television studies? Why did I still feel more confident in my nursing work than in other work situations? And what exactly was it about nursing that I was rejecting? I found myself in the library, searching the shelves for books on and about nursing. As I browsed through the history section, one character began to stand out as the focus of my interest, the figure of Florence Nightingale.

As I began to read about Nightingale, I realised how my own nursing training in the early 1970s had been firmly shaped by her dictates. It became obvious to me that any attempt to answer the above questions had to start with the influence that Nightingale's image of nursing had bequeathed to modern nursing and its professional development. The dilemma faced by both nurses and feminists in any attempt to account for the gendered balance of power in health care is posed acutely in terms of how the image of Florence Nightingale is situated in the discourses of history and nursing history. Deconstructing this image, Mary Poovey (1989) has pointed out how Nightingale used a diverse range of strategies in her writings in order to secure a broad spectrum of public support for her innovative schemes. This has enabled her 'to be read', both in her own time and subsequently, as a supporter of various reform movements that are quite at odds with each other ideologically, such as the suffragette movement and the Victorian cult of true womanhood. Pointing out how Nightingale's representation of nursing was in fact her greatest success, Poovey's account makes it clear that Nightingale was a good tactical strategist who used written discourse to achieve her aims and ambitions, although 'in her own terms- Florence Nightingale failed at nearly every nursing scheme she devised' (1989: 197).

As I pointed out in the introduction to the thesis, the mythologisation of Nightingale, both in her own time and subsequently has led to her image sustaining what are now seen as apparently conflicting images of nursing. Nightingale is known as the self sacrificing angel, the 'lady with the lamp' as well as an efficient administrator and leader. She is both the tender, compassionate, bedside nurse dedicated to the welfare of her patient and 'the battleaxe', the tough, determined organiser who creates order

out of chaos and runs her ward or hospital with military efficiency. As I read these conflicting views of Nightingale's legacy, I began to wonder if Victorian 'ideals' of nursing practice were still at the root of contemporary dissatisfactions permeating the profession. I decided to apply for a postgraduate studentship in order to undertake a project which would trace the Nightingale image not only through nursing discourses but also through popular images, on the basis that both fields of imagery were important formative influences of a female nursing identity.

My initial approach to studying nursing's image was a tentative one. After four years training as a theoretical textual critic in film, television and English literature, I suspected that some of my associates would consider an 'images of women' project banal - a point that later proved to be correct! Undeterred, I decided that I wanted to investigate the relationship between popular and professional images of nurses, analysing the relationship between these images and the images of nursing produced by women who became nurses themselves. I envisaged the project as one of textual study and library work, combined with interviews that would compliment a growing body of feminist work of a broadly ethnographic character in the area of cultural studies. Unhappy with totalising theories that claimed women as victims of ideological positionings and condemned them to suffer, silently or otherwise, the negative effects of patriarchal domination, I wanted to find feminist theories that were positive about female identity and enabling about women's abilities to create change.

Using as a basis my undergraduate understanding of feminist work from a range of disciplinary backgrounds used in the study of film, television and popular culture I

set out to explore four fields of enquiry which tend to be treated as discrete entities in separate schools of thought: the public, professional (or institutional), pornographic and personal imaginations. I wanted to know which images seemed to predominate at certain historical conjunctures, how these images related to images of women circulating more generally in society, what their relationship was to other messages aimed at a female audience or reader, what forms of communication seemed to predominate at any one time and which images gained a sufficient critical mass to resonate as remembered influences in personal accounts of nursing identities. If, as Dorothy Smith claims, femininity can be read as a text that offers a range of choices of how to live life gendered female, then finding out why people make certain choices at particular times and the influence of popular images on those choices would seem to be an important area for feminists working with popular texts to investigate.

Once I had formulated and written an initial proposal, the first task was to find a supervisor and funding for the project. After failure to secure funding from either the ESRC or the British Academy, I was fortunate to be offered a Warwick Graduate Award which enabled me to enrol as a postgraduate student in the department of Women's Studies, now the Centre for Study of Women and Gender. The location of the project in this centre influenced the way the work developed, both materially and intellectually in terms of the resources and support I was offered in my first year of study.

### **The research process**

Although I was unaware of it at the time, my first year of doctoral work was destined

to be my only year of full-time study. Most of the groundwork for the thesis was prepared during this period, which included focusing the project, finding a methodological framework and identifying the methods which would achieve my aims and objectives. There is no clear narrative to this process; I started exploring a number of different and sometimes conflicting avenues, and attempted to log my thoughts in a research diary on the basis that it would act as an *aide memoire* when I came to write this section of the thesis. Looking back now, the diary is less a reflexive record of my thinking, more a vital record of references, people to contact, and useful tit-bits of information.

The motivation to focus the project was provided by external events and stimuli: one of these was the knowledge that I only had funding for one year, and would need to re-submit a funding application towards the end of my first six months of study; the other was provided by internal deadlines set by my supervisor. Within three months, I had narrowed the project to a period that roughly corresponded to my own growth and development. It quickly became apparent to me that the period I wanted to explore was far too long a time span to thoroughly investigate, but the problem was how to narrow it down. The decision to limit the project to my own life experience was initially inspired by an analytical exercise. As part of my postgraduate training, I undertook a class in sociological methods run by Professor Bob Burgess. He asked me to present an analysis of ten autobiographical accounts of the Ph.D. process that he had collected as part of a research project he was conducting into postgraduate student experience. Strong biographical links existed between the choice of topic and lived experience in seven out of ten of these accounts, with a higher correspondence



of topic and biography amongst mature postgraduates. On the basis of this very small sample, there were no significant differences between men and women; age was the most significant factor, with mature students far more likely to have strong biographical links with their research topic. One of the questions that began to interest me concerned the role of life experience in the research process. Was it a methodological tool, aiding access and making certain procedures easier, or was it a theoretical framework informing every aspect of the research process? To what extent could the methods and arguments that were brought to bear on the research topic be the result of 'objective' analysis of the field, or were they selected because of deeply embedded emotional factors that (unknown perhaps even to the researcher) were shaping what on paper appeared to be an apparently objective analysis?

Faced with this high degree of concurrency between lived experience and research topics (albeit across a tiny sample of accounts of the research process), I decided to explore the possibility of using personal experience as a theoretical framework for structuring the research design as well as using it as a methodological tool for organising the delivery of research information. In practical terms, this has resulted in a theoretical demarcation of a period for genealogical study determined by my own growth and development, and using my nursing experience as a way of gaining access to other nurses and talking to them about their role in nursing recruitment and their identities as nurses.

It is now almost five years since the beginning of the research and the completion of the final chapter. Reconstructing the processes of research and writing has presented

a further series of theoretical and ethical problems concerning memory and accountability. The following account focuses on the decisions that have formally shaped the content of the final product, but reaching those decisions was of course dependent on a range of material factors, such as time and money, as well as ideas and influences from a broad range of sources.

Originally conceived as a project in four sections, three have been completed. By the end of my second year, it was quite clear that I was being overly optimistic about the amount of empirical work I could hope to achieve in relation to a project of this size and the time limits imposed on thesis presentation. My original plan, as presented to the doctoral committee at the end of my first year of study, was to examine the image of nursing in four different realms of experience: the public, professional, personal and pornographic imaginations. At the project design stage, I was unaware that all of these areas would involve empirical research in archives and libraries and a range of different kinds of interview, some of them in depth. I began the research for all sections concurrently, analysing and labelling material into the separate chapter categories as I went along.

The first task I set myself was to search the literature for other research on images of nurses. This bore fruit in surprising ways; it soon became apparent that British research in this field was using North American empirical research as the basis for most of its assumptions. This has numerous problems, not least of which are the different financial and structural foundations of American health care services and British nursings' relationship to them. No empirical work of comparable depth has

been attempted in Britain, apart from small scale studies of popular doctor/nurse romances (Salvage 1982) and some analysis of nursing images in Victorian literature (Maggs 1983). My first major task therefore became to locate the actual objects of study.

Informed judgement vied with pragmatics in terms of making decisions about what texts I should study or which archive I should use. A textual critic by training, I had little knowledge of empirical research but faced with a total absence of data for my project I decided to construct a data base. To achieve my aims and objectives, I needed to evaluate the popular representation of nurses across a range of media forms. I decided to focus on film, television and popular fiction, leaving out the largely uncharted and potentially vast field of women's magazines even though they were an important source of ideas and information to women throughout the post war period.

I applied for a training place in archive research, and spent a week in London with the Royal Historical Society visiting a range of archives and learning about access. This enabled me to return to London and gain entry to the archives of Royal College of Nursing, where I pursued most of the research into recruitment literature. I also spent time in the National Film Archive, locating and watching films and early television programmes, the British Film Institute Library, the public records office and numerous other specialised libraries, including the Fawcett Library and the British Library. All this work had to be done in London, involving the twin financial burdens of travel and living away from home. In addition, some of the work was both time consuming and expensive, for example the National Film Archive charge

by the hour for watching old films and television programmes.

Decisions about the form of the project were finalised fairly rapidly with only one major subsequent alteration. By the end of my second year, it became clear that I had to pare the project down, and I decided to omit the final section on pornography. Material for this section was difficult to obtain; enquiries about any such material in the archives were met with a frosty response! Whilst soft core images can be found relatively easily in general circulation, the search for hard core data proved to be more rather difficult and started to involve me in another kind of project. The criteria for all my empirical material in the section on the popular imagination was that it had to be easily available and still circulating in one form or another. Pornographic imagery, by nature of the censorship that surrounds its distribution and circulation, is difficult to obtain. Throughout my second year of study, I was working part-time, commuting between Liverpool, London and Warwick and attempting to complete the interviews and the data base. I had collected sufficient background material to begin to establish a connection between pornographic representation, images of authoritarian femininity and nursing's 'dirty work', but decided to drop the chapter in the interests of completing the rest of the thesis within the time frame.

The first year of full time research and study provided a sufficient basis on which to start writing chapters one and two. The background research combined with my own remembered experiences of becoming a nurse in the early nineteen seventies provided a foundation on which to build a structured framework of questions for the case

studies (see appendix I). Most of the interviews were completed the following summer of 1992. For the interviewees, remembering their childhood impressions of nurses and reconstructing their early lives in nursing was sometimes a difficult and emotional process. Several of them remarked that it was the first time that they had reflected on why they became nurses; remembering their pasts brought back painful, as well as pleasurable memories. For the Barbadian nurses in particular, their struggles to achieve professional status in nursing had proved fraught with frustration and disappointments (see appendix II). Transcribing these accounts, analysing them and writing the third chapter of the thesis proved to be the most time consuming and difficult stage of the process; *it was another eighteen months before the third chapter was finally completed.*

The project set out to explore a modern myth of femininity and the imaginary frameworks that mediated nursing as a social role and a personal identity for women in the post war period. It has achieved three notable contributions to the development of work in this area:

the first is an empirical study of a wide range of material which now provides a unique record of how nursing was popularly represented in Britain at the time;

the second is an analysis of nursing's identity focused on issues of gender, class and race which foregrounds continuing assumptions of professional nursing as an identity for young, middle class white women and those who aspire to such status; and finally, the use of autobiography to frame the timespan of the work places the relationship between images circulating in the popular memory, official accounts of nursing history and newly voiced memories of those events and experiences in a

useful genealogical tension that foregrounds the researcher's role in the research process.

Exploring a modern myth of femininity in some detail is an inconclusive activity; it helps us know more about the world we live in or have lived in, rather than breaching new theoretical frontiers or providing statistics to support policies for change. Nonetheless, this kind of cultural work is important and necessary; locating how different images of femininity are defined and organised depends on how more general processes involved in constructing meanings, identities and images are understood, which can lead to very different strategies for resistance or change.

This final section, written in 1995, has involved stepping back and reconstructing the processes of research and writing, processes which have inevitably undergone considerable change and development throughout the five year period. The final stage of completion has inevitably included a further period of analysis and reflection, which has brought into sharper focus the relationship between institutionalised discourses and the formation of female identities. One of the identities now available to a minority of self-selected women is that of the feminist researcher. Constructing my 'self' as a feminist researcher is a very different process to constructing one's nursing 'self', but there are strong parallels between becoming a 'proper nurse' and becoming a 'proper feminist'. Both demand enormous investments of time, money and emotional energy and an intellectual engagement with institutionalised discourses that shape and define the public presentation of the self. In this final section, I want to open out a little the question of constructing the self as a feminist researcher.

### **Constructing the research 'self'.**

In an early unpublished essay on research methodology I tried to make an analogy between the human subject as constructed in the discourses of western science - as a unified, coherent whole - and the researcher, who is presumed to be a unified, coherent whole because the conventions of academic writing demand that they 'pull themselves together' on paper. I proposed that research itself is an activity that constructs the researcher in relation to their intellectual and lived biographies, a point similarly made by Stanley and Wise in **Feminist Praxis** (1990a). Whereas Stanley and Wise emphasise the role that intellectual biography plays in the research process however, I argue that lived experience can shape both the choice of research topic and its intellectual trajectory.

I started to think about whether there was such a thing as a feminist methodology, and if there was, what it might look like. Rather than focusing on questions of method that argue, for example, that qualitative methodologies are 'more feminist' than quantitative ones, that women interviewing other women are more likely to achieve an equal relationship with the subjects of their research or that collaborative work is more 'feminist' than single authored work, I became interested in autobiography as a structuring tool for my research. What would it mean if I admitted my subjective engagement with the material, rather than hiding it in an objective discourse? Could this be one way of thinking about the feminist maxim that had played such a large part in my decision to leave nursing, that the personal is

political?

At the end of my first year of research, I presented a paper with a colleague that spelt out our respective feminist positions on issues of representation and sexuality, and how we saw those positions connecting to broader issues of feminist epistemology and ontology. We begin the paper with a quotation from Audre Lorde that emphasises the need to be alert to change as we grow and develop together our individual feminist consciousness's:

‘Change means growth, and growth can be painful. But we sharpen self-definition by exposing the self in work and struggle together with those we define as different from ourselves, although sharing the same goals. For Black and white, old and young, lesbian and heterosexual women alike, this can mean new paths to our survival’ (Lorde 1984).

We go on to argue that as feminists, we want to be part of developing a knowledge base that is multivocal and multivalent, and that the key to this process is a more self-reflexive research practice that thinks less about whether its methods are intrinsically feminist and more about whether it achieves feminist objectives. We pose questions for ourselves such as ‘Why is this knowledge being produced?’ ‘Who is producing it?’ And ‘what kinds of political effects is the work likely to have?’ (Hallam and Marshall 1993: 68). I would now add to that list ‘what kinds of feminist effects is the work likely to have? In the conclusion to my section of the text, I state that ‘a more self-reflexive research practice which is clearer about the choices it makes and why it makes them serves a feminism which still abides by the notion that the personal is political (Hallam and Marshall 1993: 75).



Feminist academics from a range of disciplinary frameworks have become increasingly interested in the position of the researcher vis a vis the research process. In social science, the turn to the role of the self in constructing knowledges about the social world tends to follow a feminist ethnographic impetus that place participant observation and in-depth interviewing at the forefront of qualitative research methodologies. In the arts and humanities, the turn to the self tends to have been theory led, hinging on the reader-text relationship, with the self-as-reader-as-critic increasingly forwarded as the central problematic of 'reading as a feminist' or 'reading as a woman' (see, for instance, Mills and Pearce 1989, Probyn 1993).

Both areas of work are now beset by issues of interpretation, qualification and an increasing self-reflexivity. Who do feminists speak for? Who do they speak to? How can they avoid objectification of the other, whilst still maintaining a place for themselves? Finding a place from which to speak and write is no longer a matter of adopting the language of the academic expert. As feminist academics, *the way we* use language reflects our own relationship to the institution in which we find ourselves, an institution that depends on its existing discursive formations to maintain its power and authority. As Smith (1988a), Steedman (1986) and others have pointed out, institutionalised discourses function on categories of difference, because difference is the essential component of any hierarchical organisation; sharing experiences with women in similar situations as oneself (what used to be known as 'consciousness raising') can illuminate these differences. But perhaps, more importantly, as Caroline Steedman and Dorothy Smith point out, what is revealed through such an exercise is both the power and the limitations of dominant discourses

to conceptually shape female identity.

‘Feminist research practice should never lose sight of women as actively constructing as well as interpreting, the social processes and social relations which constitute their everyday realities’ (Smith 1988a: 34)

This thesis contributes to feminist knowledges of the processes of female identity formation through an analysis of the socio-cultural construction of images of nurses. I have argued that the white middle-class identity of nursing that dominated popular fictions and recruitment literature throughout the post war period was not only representative of professional ideals and practices but also constitutive of those ideals and practices. In spite of the enormous changes in patient care brought about by changes in medico-scientific knowledge and the re-organisation of the health service, professional status and autonomy in nursing continued to be anchored in an ideal of femininity rather than in the specific skills, methods and knowledges of nursing practice. Throughout the period however, nurses themselves increasingly challenged and questioned this restrictive professional ideal, exposing the fissures in this image of selfless devotion and supplicancy. These deep cracks divided the workforce, revealing the colonising assumptions of the professionalists and the subsumption of difference into an all encompassing ideal of middle-class white femininity. As the interviews with women who became nurses revealed, their images of what might constitute a ‘proper nurse’ have - like my own - much in common with the dominant nursing discourses of the time. But their reflections and reconstructions of their nursing lives give voice to some of the disjunctions and ambivalences that have fractured the ideal concealed within the discourse of the ‘proper nurse’. Other

narratives of nursing history are revealed in these accounts, narratives of assimilation and difference told by experienced practitioners of their struggles to claim value and status for their nursing work. These stories can be found in the National Sound Archive, where they currently constitute the only unofficial voices of nurses talking about their professional identities in the post war period. Another history of nursing is waiting to be written, one that recognises the marginalised identities of experienced practitioners and places their struggles for professional recognition and autonomy at the centre of the story.

Constructing myself as a feminist cultural researcher has been a lonely process at times, but I have received help and support from several collaborators, most notably my supervisor Terry Lovell and friends and colleagues Sheila Campbell, Anneeka Marshall, Margaret Marshment, Nickianne Moody, Karen Lury, Kay Richardson, Maggie Scammell, John Corner and Diane Shannon. My thanks to you all.

## APPENDIX 1

### Framework for structured conversations with interviewees.

- 1) Can you remember what images you had in your mind of nurses and nursing before you became one yourself?

How did you see the nurse and her role? Where did you get these ideas from?

(Then try and locate the source of these images - relatives, personal experience of nurses or hospitals, a curiosity about medicine and medical mystique, educational influences, *books, magazines, radio, TV, films etc.*)

Perhaps a prompt about Nightingale here? Or ask directly?

- 2) Did these images have any impact on you as a young child?

Did they lead you to imagine yourself as a nurse through game playing?

- 3) What was the major influence on your decision to become a nurse? Did you consider any alternatives? Or see it as a path to something else? (I'm thinking here of Air Hostess's in particular). How did you see your future?

- 4) How, in a practical sense, did you actually become a nurse? (role of parents, careers officer, school, hospital recruitment, nursing cadet, choice of training

hospital etc.)

How did your friends and relatives respond to your decision?

Did you ever try an alternative line of work?

5) What was your experience of being trained? (This should include donning a uniform, living in the nurses home, rules, pay, hours, study etc.)

6) Did any particular people make a significant impression on you during your training? (Other nurses, doctors, ward staff, patients etc.)

7) What were your relationships with other members of the nursing and hospital staff? (social, professional, with whom ...)

Do you remember noticing how nursing was popularly represented at this time? (Films, TV programmes etc. Or the lack of them?)

8) Do you remember your graduation ceremony?

Did you have a clear plan of what you would do once you graduated?

9) What posts have you held since qualification?

10) Has your view of what nursing is changed over the years?

Has it fulfilled your early expectations?

What is your image of today's nurse? (Try and see whether this is positive e.g competent, efficient, professional or negative e.g in a weak position in some

way, over technical etc.)

- 11) What do you think about the way nurses are currently represented by the media? (Issues around pay and conditions, fictions like Casualty etc.)

What do you think the popular perception of nurses and nursing is today?

- 12) What do you think about the moves to a college based education for nurses?

And Project 2000?

- 13) Do you think nursing is less attractive as a career for women than it used to be? Why? Or does it offer more to women as a career than it used to?

Thank you.

## APPENDIX II

**Interviews with women who came to Britain from Barbados to train as general nurses in the 1950s and 60s.**

KEY: [...?...] - word or phrase indecipherable.

[?] - word or phrase unclear; probable version given.

N.B. White British transcribers have worked on these tapes.

V Came to Britain from Barbados to train as a general nurse in Kent, early 1950s. She became an auxiliary nurse in a geriatric hospital and has worked as an auxiliary since then, primarily caring for the elderly.

JH Can you remember what image of nursing you had in your mind when you were young?

V When I was little a child growing up, I have to say that there was some of my friends that was also nurses and I was thinking about I'd like to be a nurse because I like the uniform and clothes and so on, so when we finished school - we used to play in school like nurses, different little games we used to play and what happened then - when I leave school then the doctor started giving classes for girls that leave school for nursing and I went to needlework instead. I didn't go but some of my friends went to these classes, and then they went into hospital working and so on but I was into sewing classes instead. But then after I'd grown up and they start emigrating to England and

me that these girls went up to the hospital and if I go to the right one of them so I says OK so I look through the book and wrote to three of them and get a reply from all of them but I liked Maidenhead and I went to St. Marks hospital, Maidenhead and stayed. Yeh. So I feel that if you're leaving your country you should always got somebody to live and by writing the hospital I had somewhere to live because I had a family here. So we went into where we come in, after I come in we was welcomed and shown round the wards and so on and to our room that's all. And the next day we start work. So ...

JH Bit of a shock!

V Yes. And the first thing that greet me was a body actually, some sister came up to me and said you ever seen one and I says no so she take me to he balcony and she showed me this patient. But I was a bit scared, I just went and I peeped and I come back with the [...?...] student girl that was there and sister said to me, well, that there was nothing to worry about, that everybody is scared at first and then they get over it. So...

JH Did you have a uniform?

V Yes, we get uniform. We had a funny uniform that the girls was wearing then, and caps and up.

JH How did you feel in uniform?

V I did feel good but I didn't like them really because it wasn't a dress, it was like a tunic, you know. They wasn't dresses. But I did like a uniform.

JH Did you get a hat too...

V Yes, we had a hat.

JH Cloth hat?



- V Yes.
- JH Did you have cuffs?).
- V No.
- JH Did you have any notion before coming to England - had you heard of Florence Nightingale or Mary Seacole or...
- V Um, we heard people talk about Florence Nightingale when I was growing up but I never go into it but later, after I came into England, we start saving things of Florence Nightingale and that kind of thing so I start thinking about what she was doing and what she did and so on.
- JH What did you think of her?
- V I don't really know what.. I think that she do a good job but it was a bit risky with some of the things that she do, you know, and these dark places looking after these sick people and things that she was really good.
- JH When you decided to come and be a nurse did you ever think about doing anything else?.
- V No, not really.
- JH You said you changed from sewing
- V Yes, I preferred um sewing. I like light work like nursing I like that because it's not very hard I would say. It's a lot you have to put a lot into it but I think I like it after a while. For the first - I think for the first of anything nobody don't like and I didn't like it at first at all to a certain extent, I did like it but not to that extent because of certain things that I had to do that I think was beneath me.
- JH Yes, some of the work is quite hard.

- V Yes, but after I get over that cause of just like emptying bedpans and so on and putting patients on commode and have to clean them and that type of thing, I think that I wasn't qualified for that, that wasn't me, but after a while I get accustomed to it so I didn't mind after that.
- JH Did you find you were dealing with lot of elderly people?
- V Yes, yes.
- JH Was it a hospital for old people?
- V It was a geriatric hospital.
- JH Did you know that when you went?
- V No, I didn't know really what kind of hospital it was but after I got there then there was a lot of elderly people, I liked the old people and there was a lot of elderly people, yes, but I didn't mind.
- JH Go back a bit - did you have to fund yourself to England?
- V Yes.
- JH No government sponsorship?
- V Yes, there was government sponsorship but I didn't go into that. My parents paid for me to come here. So - because you have to go through so much formalities if you want to go into government and so on so I do all the formalities myself.
- JH Did you ever think might use your nursing to travel or do something else?
- V After a few months I was thinking about doing my training and to leave the country after I finished my training because it was in as when we leave home we leave for three years or five years and we say

well at the end of five years we going back home and but after leaving a family home and then you got the mon the pay you got was so small I couldn't afford to my training then... so I decided to carry on working as an auxiliary. I was ah in this country I was here 17 years before I could ever go back to my country because in them days your living in the hospital and ah the wages at the end of the month are only £8 £9 and it just depends - if it's a 5 week month cause some months have five weeks the ,money was too small so...

JH So you were living in... Did they stop money for rent and food?

V That's right, yes.

JH So you were left with a small sum.

V That's it, yeh.

JH It was difficult for you to do anything else then?

V Yeh.

JH Who else was training with you?

V Well there was a lot of girls that came in after me at the hospital and mainly there was about 4 of us who used to live near together - three of us was in one room and so on. And all of us had a family and none of us - well, I would say about three of us didn't go into our training because our family was big. The um - there is two that after about 2 years went off and do their training, yes, and qualify as SEN, but um there was another 3 at least that didn't push it because um they had their children with various um people and some of them been sending back no money for the kids or anything like that

but I think that it was right to send money for my parents to look after my children, and therefore I decide to, what they say to cut your nose to spite your features.

JH Could you have trained as an SEN in that hospital?

V I could've trained but the sister that was on the ward that I went on, she was very good to me. I was there two weeks when she start learning me how to write a report, she teach me how to give an injection, she even carry me along with her when she's giving the medicines and some of the girls was really jealous that been there before me because they said that I just come and Sister got me as her favourite and that type of thing but I got to thank Sister Ellis for a lot of things and I thank her for whatever she learn me.

JH What was she like?

V She was um tall and slim you know...she was nice, she was friendly

JH Some times you could work with Sisters who were quite rigid.

V No, no - she was genuine, Sister was genuine because She... she was that nice to me that if she got anything she would give me like big box of chocolates, she would bring in and give me. She was very nice, she teach me everything that I know, I teach... learn nothing at no other hospital that I worked at and I - I like to learn...

JH Did she teach you how to do things like treat pressure sores?

V Yes, She was very good and I think that the teaching that you get in the sixties was a lot better than the teaching your getting now because the auxiliaries have no role to play any more. You just go on, you're just labour yeh? but in them days' you know when you want to work you've got your

work set out, you'd do the ward, you'd do your tables, you'd do your backs and you get you... and then they seemed to have lint, zinc and castor oil and when you done your bed round you plaster the zinc on the lint, and so that when you go round with your back trolley so if there's any bad backs you got everything there ready to put on it. These days there's nothing like that.

Ly That was ritualistic, wasn't it really. The wards now is dirty the patient's locker you can't even put anything on it, because it's not cleaned, you know. Nurses now, they just come in and walk around and may give a patient a bedpan or another one a bed bath or something...

JH What about the Drs - did you see much of the doctors?

V No, not really. Well the thing is if the doctors around he tends to be with the Sister, the trained nurses and so on, they don't bother with the auxiliaries any more.

JH How about in the hospital generally - you were saying that there were a lot of women from Grenada and Trinidad...

V Trinidad and Antigua, Guyana, Jamaica. You have a mixture of people working, mainly women and the staff that was in the kitchen, the staff, that was the domestics, was from um Italian, there was Spanish, and Greek and we had a few male nurses which was um Italian, Greek and Spanish.

JH You were saying people looked out for each other.

V Yeh. It was a good atmosphere - We never had no problem with the staff or nothing. We even had we even build up a relationship with a butcher that was not far from the hospital and he would.. we would go to him and he would give 2/- in meat. The matron say to give us food but not meat so we would

go down to the to this man called Mr. Turnwood and he was 'Oh poor nurses, they don't have any money' and he very he give us a mixture of meat you know for 2 shillings and when we off duty we would cook all our own food and share it with the other girls that were there and when they're off, they would cook you know.

JH So how was the matron?

V She was good, she was good, she used to come up and look for the girls and talk to them and see how they're going on. And I remember that the first year that we see snow and I was - about that night I had a friend and when we came in the morning the hospital grounds was full of snow high, and all the girls was playing in the snow and the matron was through the window looking in, laughing. She was fascinated because the girls never see snow before, and all of them was in the snow you know, and I think she enjoyed that. She just was through the window couldn't get over how the girls was in the snow making so much noise and that kind of thing.

JH Was she a very [...?...] woman?

V Ye-es. Yes she was.

JH But she wasn't unpleasant to you?

V No, well she would be only unpleasant if the girls do something wrong yeh? like one day I was walking and the sun was out and I had my cape over my hand and it was the [...?...] was flying and she pulled me up about it but I didn't mind. But we had one sister there that she wasn't... nice at all and she was called Miss Sliver and she... She was nice in a way because the ward was clean but I think she was prejudiced, always liked to be shouting at you

and you know and you got to be um... She's more or less like a sergeant major yeh? But I didn't like her I don't think she did like me, y'know, because she tell me something that I didn't do, and I never forgive her for that. Otherwise than that everybody there was alright. We was treated with respect there. When I was leaving and the matron said to me that any time I want a job there's one there for me. That I could go back anytime.

JH And have you found things very different in Oldham?

V Yes, yeh.

JH How did you come to go to that hospital?

V In Oldham?

JH Mmm.

V Well, we leave Maidenhead um in '63 because this friend of mine...xxx the hospital after she got pregnant and came into Oldham and she keep writing and saying to me that the houses up here cheap and so on and by that time I had a baby and I keep getting... I start to live out the hospital then and they keep getting um no children and we found that getting accommodation was very hard to get if you had a child. We put in for the council house and we couldn't get one, there's always an excuse and then you couldn't buy a house because they was asking £1000 for a deposit so we decided so I says well, we'll live up here. But we went to Sheffield for 7 weeks, spend 7 weeks in Sheffield then we move over here and we've been here ever since.

JH Were they advertising for staff?

V Yes, yeh.

JH Did you start on days or nights?

- V I start on days first and then went on nights.
- JH Did you find it better on nights?
- V Yes, I find it better on nights because of I had my son and there was no um you couldn't get nobody proper to keep the child and I find that it's better if I work nights, and um look after him during the day.
- JH But you weren't so keen on the hospital?
- V Yes, after a while - after I came into Oldham and I get accustomed to working in Maidenhead I decide that there's nothing else that I could do but nursing and for a while I had a job in a factory and I didn't like it, I was pressing so um I work a week and the manager or whoever she was, she called me and she said to me what work I do. I says I was nursing, she said if she was me she'd go back to nursing so she give me my cards because (laugh) she must have realised that I didn't like what I was doing.
- JH So over the years, do you think your view of nursing has changed?
- V Yes.
- JH What are most significant changes that you've noticed?
- V I would say that over the years nursing has changed with what Ly say that the students are going into school and coming out now and they... they isn't working on the ward like years ago when you come when you go in, apply for a job as a nurse, you go and you work on the ward and you know all about your patients and what round they've done and so on. What they're doing now, they're going into college and they're coming out and um
- Ly It's their whole attitude
- V They only work, they're only doing nursing by paper.



- JH Do you work with student nurses now?
- V No because I work nights and the students is in the day. But they leave rules, they lay down the rules, say that you musn't do this to a patient and that to a patient. They think what they learn in college is what you should do, which [...?...] as well.
- JH When you're on nights who do you work with?
- V Well, I work with trained staff, SEN or whatever. Now, since they moved to North Manchester, the staff there is a lot different to the one in Oldham and other places you know, that I work. North Manchester staff is a bit well I think what happened there is that they look after their own and we come as outsiders, now we're there.
- JH And what do you think nurses on television are like, like on *Casualty*....).
- V I don't watch *Casualty*.
- JH You said earlier you had a memory of *Emergency Ward 10*...
- V Yes - I don't remember much about that it was so long.
- JH Did you watch it?
- V Watch it, I used to watch it but um that gone clean from my memory.
- JH Did you enjoy it?
- V Oh yes I used to enjoy it. I don't watch *Casualty*, not that I don't enjoy it, but I never remember it on, I always watch something else.
- JH Do you think nursing's less attractive now, do you think it's presented differently?
- V Yes I do.
- JH In what way?

V I think it less attractive because of the staff uniform and - just that really. It's less attractive - the staff uniform is one, and the staff attitude to the patient, uh...

JH Can you say a bit more how you think that's different?

V What I think is different I were going to say mainly about the patients because years ago when you had a ward of patients in the morning, you know that your patients going to get a proper meal, midday a proper meal, in the evening, a proper mean. Now the patients can't even get a slice of bread. There's no breakfast coming out, no bacon or eggs and I think it is wrong for the old people because they have worked all of their years and at the end of their life I think they should get treat better, think they should be able to sit down and enjoy what they used to have throughout their years. Patients now ask simple want a piece of bacon, to taste baked beans, eggs, or something, they don't know, they don't get it for breakfast. So that is why I think that is the main attraction that gone out of nursing.

JH You can't satisfy patients in the way you used to?

V No, no (sadly).

JH Is there less staff?

V No, I should say that there are more staff on the ward now, during the days there are more.

JH Do you think patients benefit from more staff?

V Yes,

JH Are wards less clean?

- V That is not the nurses fault that is the nursing sister's fault because if you got a ward, you got your domestics and you should make sure that the domestics are doing the work, yeh? that they clean the ward. That is not the nursing staff at all. The nursing staff duty is like cleaning the lockers, changing the flowers, and the vase and so on but like mopping the floors, polishing the floors and that sort of thing that is the domestic, and if you drop a piece of anything on the underneath the chair, the table or the bed, when you go back the next night it's still there. They've not cleaned it.
- JH Do you think the NHS is less good?
- V Yes, yes (sadly)
- JH Doesn't it provide the same care?
- V It doesn't no. Sometimes you go on the ward, you can't get a cake of soap, there's no dettol, there's no savlon, there's nothing no more on the hospital ward. It's awful.
- JH Is that the same for things like hand cream?
- V Yes, yes you can't get anything there like that any more.
- JH So, all in all, for women to go into nursing now, it's less attractive? Or is it still a good career?
- V It is still a good career if in case they go back to the old method of nursing,. I was meaning I thought as years go on, you think it improve but for nursing I don't think you should improve so much because for the patients sake, I think there should be more um attention given to them.
- JH Do you think that's altered your job satisfaction, knowing that things are there for you to be able to provide for the patient?

V     Yes they were better.

JH    You feel your role has changed?

V     A great lot, yes.

JH    You feel more...like you're treated not so well as you were years ago?

V     Yes, that's right. Sometime it make you wonder, sometime I feel sad, I mean, sometimes, it makes me feel sad sometimes because I feel that I should've done my training and I suppose I was treated better, because, sometimes you get some young little staff that just come out maybe I was a nurse before they were born and oh want to push you around and it make me feel sad (very melancholy).

ENDS

G Came to Britain from Barbados to train as a nurse in the early 1960s at a small, semi-rural hospital in Yorkshire. After qualifying as an SEN, she upgraded her qualification to SRN in the late 'sixties. G worked for eighteen years as a hospital Sister, but has now left the NHS to work as a practice nurse.

G My name is G. And I've been nursing since 1961.

JH When you first started nursing, did you have a particular idea in your mind of what nursing would be like? Was it something you'd always wanted to do?

G I've always wanted to be a nurse from... little.

JH Did you have a relative that was a nurse?

G No relatives that I know of, no.

JH No. No. Where did you get the idea?

G My mum planted it in my head.

[laughter]

Yeah, she kept saying: "Should be a nurse. Should be a nurse", so... it just grow in my head, I suppose.

JH And did you play with any games...

G No, not really.

JH ...To do with nursing?

G No.

JH You didn't have any friends where you pretended to be doctors and nurses?

G Not that I can remember, no.

JH No? And did you read any books about nursing? Magazines or comics?

G Not particularly. Never really connected up with it at all really, no.

JH At what time did it start to become a reality?

G Well, I was about sixteen and at that time in Barbados there... You know, what we're getting time to be leaving school. And we were starting to think of careers then. So, then I started thinking seriously about it, because then you went to school until you were about eighteen. So it was not, well[?], sixteen. And the government in Barbados was recruiting nurses for England, and me and a few friends of mine decided we would go into it that way.

JH Right, so you kind of look up the[?]....

G That came out the government, yeah.

JH How did they... you get to hear about that? Can you remember? Was it advertisements in papers?

G Well, I mean Barbados is only a small island, so all these things are on the radio.

JH Right.

G Teachers at school are in connected... in connection with, you know... the...

JH Careers teachers.

G That's right, yeah.

JH And did you have an idea what it would be like to be a nurse, what the job was like, or... that kind of image?

G Not particularly, I have an image of just looking after ill people.

JH Yeah.

G Mmm. Nothing else really. I had no other idea.

JH You had some ideas, though?

[laughter]

So, how old were you when you left to train?

G Er... seventeen.

JH Seventeen?

G Mmm.

JH And you came then to England?

G Came straight to England. We went to Otley in Yorkshire, where we... way out, it was. A group of us - we came in groups then - there were four of us - to a little hospital in Otley, to do... We were pupil nurses, you know, to become enrolled nurses.

JH And that was in 'sixty-...?

G One.

JH 'Sixty-one. And can you remember arriving in England?

G Very well[?]. Even though it's all that long ago, I can remember it as though it was yesterday. I didn't like it. We got into Gatwick. The journey was... took ages. It seemed ages, it might only have been about ten, twelve hours, back in 1961. And we got into Gatwick and someone met us. Some representative got us all together and we went on a train to Victoria. And then we got this train from Victoria to Leeds. And then from Leeds, a little van from the hospital came in the wee hours of the morning to take us to the hospital. Long journey. I can remember it well.

JH Yeah. How many of you?

G Four.

JH Not many really, was it?

G Four at a time. Four at a time, you know, but there were others there when we got there. And there were about ten of us in our... from the West Indies.

JH And when you got there, what was it like? What were they like when you arrived?

G They were nice. I always thought the Yorkshire people were very friendly.

JH Were they?

G They were very nice. They tried to make us feel at home, you know, but it was very strange.

JH And how soon after that did you have to start work?

G I think... Pretty soon, I think. We only had a couple of days to get used to the environment, and then we were on the wards. And we didn't actually go into a school first. We went on the wards and then after about a week, then we went into school.

JH And they kitted you up for your uniform then?

G They did, hmm.

JH Must have been quite fast, to...

G Strange. It was really strange.

JH And you put on your uniform?

G Yes.

JH Did you have... what colour?

G Erm... Green.

JH Green, it was...

G Yes, it was a green uniform. Used to wear aprons and cap and a white belt.

JH Yeah. And you went onto the ward and how did you feel?



G I felt strange. And I felt strange because everybody was white.

JH Sure. I should think it would be a real shock.

[laughter]

G So, I felt strange but it was nice because - like I said -there was eight other black girls there. And they all sort of... soon as they heard the new ones were in, you know, they came to introduce themselves. And they were around to let us feel at home. But we were very homesick.

JH You were in the Nurses' Home?

G Yes, we were in a Nurses' Home.

JH Yeah. Yeah. And how did you find the work?

G Erm... I quite liked the work, because, as I said, the Yorkshire people were very friendly. I think we were lucky in the sense that we went to that area, cos the people were very friendly. You know, after a while we didn't feel strange with them, because they made us feel at home.

JH Yeah. Bit different to some people's experience.

G I know, mmm.

JH And you didn't have any fears about handling bodies...?

G Not really. Not that I can remember. I remember the first man that died was the first person I ever saw dead. And to me, you know, everyone was concerned for me, with it being the first time and I went in and I looked at him. I can remember his name - he was called Mr. Stone. It's amazing how these things stick in your head. He was called Mr. Stone - he was quite a large man - and I went and I looked at him and he just looked as though he was just sleeping -just that his stomach wasn't moving. But I wasn't

frightened or anything like that. And that was the first one. I'm more frightened of them now!

JH Than then?

G Oh, dear.

JH So having arrived - I mean... - and made that decision, your mother clearly supported your decision, did she, when you were at home, to leave...?

G She did, yeah.

JH ... Come and do that. So your family were behind you...?

G They were behind me, yeah.

JH ... Supporting you. So, once you were here and you were working, I mean, did you get a sense that your family was proud, even though you were removed from them?

G Yes, I did, yeah. Mum, she was always interested in what I was doing and how I was getting on, the different people I was meeting and... She'd always be interested. She's always been a pushy... a pushy mother.

JH Yeah. And what about in relation to working in a hospital in Barbados. Did you think then that you were in a very different situation?

G I didn't think of it then, because I just thought well, nursing is nursing. So I didn't see it in any different light.

JH Did you think you'd go back?

G Oh yes. Initially when we came we were only here for five years. Everybody would tell you, oh, just going to England for five years. And I'm still here.

(laughter)

JH So once you started your training, did you ever think of doing anything else?

G Apart from nursing? No.

JH You didn't see it as going on to do something after? Quite happy to...?

G I was quite happy.

JH To stop, yeah. What people... what were people like? Was there anyone that made a real impression on you?

G When I first came?

JH When you were training.

G Quite a few people. I can't remember her name now but the Sister-Tutor, they used to call her in all those days gone by. And then we had an assistant matron or a home-warden or something, they used to call her, that used to live in the Nurses' Home called Mrs. Gaunt. She stand in my mind. A charge-nurse - now I can't remember his name but I can see him now - and a sister called Sister Thorpe. And Sister Co... the sisters, because it seemed that I was in awe of them. They were, you know, up on a pedestal or something. Those names stand out in my head.

JH And were they people that you got on well with, do you think?

G I got on well with Sister Thorpe, but with Sister Cochran, no. And the Sister-Tutor was real cruel-looking, you know. She was strict-looking and... we thought we were[?] scared of her. If the Sister-Tutor was coming you were, you know, stand at attention and all this.

JH And was everybody like that?

G Yes.

JH Yeah. Yeah. So she wasn't just picking on cert...

G She was like Hattie Jacques in the Carry On films.

(laughter)

JH Did you go and see those films?

G Yes.

JH And... did you enjoy them?

G Ooh, lovely. They were brilliant.

JH Did you think they showed it as it was in the hospital?

G Erm... They were quite good in a way, but I think they're, well... comedy because a lot of it was related to - in those days, not now - like the matron and all that, and the silly things that nurses used to do. You know?

JH Yeah. Make sure all the bed [...?...].

(laughter)

G The corners and...

JH The corners... and that stuff. So, as you went through your training, what did you think of things like the pay and the hours, the study...?

G The pay was absolutely paltry when I started. We used to get, in our hands, about nine pounds a month. And the hours were forty-eight hours a week.

JH Long hours.

G Long hours. The pay was terrible.

JH But you kept going?

G Just kept going, because you didn't really think anything else, you know. You just got used to it, but [...?...], look [...?...] had it now. It's awful. [...?...]

JH Long hours?

G Long hours.

JH And you had to study too?

G Yes. Yes.

JH And you'd got no time?

G No time for socialising much really.

JH And what was your social life like then, in this little...?

G Our social life, because Otley was such a small town, we used to Bradford and Leeds. There were lots of Africans who were studying at the University there, so we could go over there. When we were in the Nurses' Home, we used to watch television. And we had a recreation room where you could go and play tennis, or things like that. You could have... invite your friends to come and see you, and go in the recreation room and play a record. Things like that, but... we didn't have a lot of social life. And the Yorkshire people used to invite us to tea quite a lot. A few of us would go together to some of the Yorkshire people's houses for tea.

JH Mmm. So by the time you came up to qualification, was there some sort of ceremony? Did you have a graduation?

G No.

JH Anything like that?

G No, there never was, no.

JH So they didn't make an occasion?

G Not really, no.

JH But you got your...?

G The first... Well, I did my SEN but there wasn't any sort of celebration then. Then when I did my General, there was a prize-giving ceremony near Stockport, where you went to collect your certificate [...?...].

JH Yeah. How long a gap between your General and your...?

G Erm... I finished SEN in '63. Then I started my General but stopped, cos I had two children. Then I started it back in 1967. And I finished in 1970.

JH So once you qualified as SEN, you were then working on the wards?

G Yes.

JH Did you do a speciality or...?

G Not really because the hospital was general. It was a nice little hospital with one medical and one surgical, a geriatric ward and one maternity ward. Cute little hospital. And a children's ward they had, as well.

JH But very local.

G Very local hospital, mmm.

JH And did you move from there to do your training?

G Yes I did. I came over to Ashton, and I started there, and then I left. And after that I went off and I did ophthalmics - a certificate in ophthalmics I was looking for. And then I went to do my General. So that's where all that time was taken up.

JH Yeah, yeah. When you started your General you had to go back to be a student again.

G I did, yeah.

JH Was that hard?

G Not really.

JH No.

G No, I find it... you dwell on that too much, cos I just wanted to, you know, get me...

JH Determined to get it?

G That's right, yeah.

JH Yeah. Was your determination based on the fact that...? Did you know there was the two trainings?

G Before? Before we came to England, no. A lot of us didn't know until we got here. They never let us know over there. And they used to decide - favouritism, I guess - who they sent to do Enrolled nursing and who they sent to do the General.

JH What, the government office?

G Yes. There were two ladies who sort of used to do the recruiting at this office. Like, if your face fit you go and do your General, and if it didn't, you went...

JH But who were they? White matrons?

G No. No, they were black. They were Barbadian blacks.

JH And they picked?

G Picked.

JH And when you found out that you were doing the SEN, and not the SRN, did that make you distressed?

G I was unhappy.

JH Yeah.

G Cos I felt that I was educated enough to have gone straight to do my... and

got... the two years was a waste of my time.

JH Yeah.

G A lot of us felt like that.

JH And who managed to help you with that here? Anybody? Did a matron at the hospital or...?

G Not, not really.

JH Nobody?

G No. As soon as I realised, you know, what was happening, I decided, well, I'll go ahead with the training because we were on contract to the government anyway, so I were contracted to the hospital, so we had to do the two years. But as soon I had... I was determined that as soon as I finished, I was going to do my General.

JH So your government knew about the SEN?

G Oh yeah. They did, yeah. They knew.

JH And you actually had a contract that kept you before that?

G Yes.

JH So you had to stick at it?

G Had to stick at it.

JH You couldn't... change? Right, right. So, yeah. That must have made a difference. Did you then... how did you find out about how to do your General? Through nursing magazines?

G Nursing magazines, and the nurses in the hospital, and this particular sister, Sister Thorpe. Perhaps that's why I remember so well, you know. She gave me all the info.



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JH She gave you? Did she encourage you?

G She was encouraging, mmm.

JH And once you started your General, did you find there as well that people were supportive?

G Erm... I'm going back now though - when I first started at Ashton. Yes, they were actually. Yes.

JH And how many people were training with you, like a thirty [...?...] PTS or something?

G Yes, there was a PTS. Erm... I think there were twenty-something of us.

JH And that would be black and white nurses?

G There were black and white, male and female.

JH Yeah.

G There were a couple of males in there.

JH How did they get on?

G They were all right. They were all right, yeah.

JH And how long did it take?

G For me to finish? Two-and-a-half years. I did it in two-and-a-half years. They only took six months off, being Enrolled.

JH Not long?

G No.

JH And where did you go once you were General-trained?

G Well, I stopped at Stepping Hill. After I qualified, I was a Staff Nurse for about nine months. And then I went back home for the first time. And that was ten years after I'd left. And I was there for eight months. I wasn't

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coming back. But then, I came back.

JH And how did you feel as a Staff-Nurse in your uniform after all that work?

G Brilliant.

JH You did?

G Mmm. I was that proud of myself, that I'd achieved it after all that time. I mean, it took me a little longer than it should have done but I did, in the end, and I felt proud about it.

JH And did you have a different uniform in the end?

G Yes.

JH What was your uniform?

G Navy blue, but not that dark navy. Yeah, a light kind of navy.

JH And were you... I mean you were still wearing hats?

G We were still wearing hats, yes.

JH Yeah, so you had...

G Just an ordinary cap, but...

JH Yeah.

G We were still wearing them.

JH So you did feel proud?

G Yeah.

JH And then, since then you've been working fairly regularly?

G Uh-huh, I've not really not worked. After I came back from Barbados I went to work at St. Mary's, which is a gynaecological hospital. And then I worked there for six years - 'seventy-two - six years. And then my mum writ to me - could I deliver babies? And I said no. So she said, well, you're not a full

nurse as far as I'm concerned till you can deliver babies. I mean, I really wasn't interested in midwifery at all. But then because she said that I went off and did midwifery for a year.

(laughter)

JH So you did a year?

G Did a whole year, yes. Quite enjoyed doing that. But I never practised. As soon as I'd finished, I came out, back to gynae again, cos gynae's my favourite.

JH Is that where you are now?

G No, I've left that.

JH You left?

G I left a year ago. Took redundancy money.

JH So you... were you on the gynae... were you still on the gynae ward when you left?

G Oh, yes. I've done nothing else but gynae. I just loved gynae from the very time I started nursing. Gynae was always...

JH Sister by the time you left?

G Oh yes. I've been a sister for... from 1979.

JH Yes, so you were a sister for what? Ten years?

G Twelve.

JH Twelve years. And why did you decide to leave?

G Well, the grading system. It was all very unfair. There was myself and the other sister on the ward - we were both at the same level. And because of the grading system, because of the money that they had to - you know, the

problems with the money that they had to... save or whatever - they had to give a G grade and an F grade on the ward, even though... I mean that caused a lot of trouble in the hospitals everywhere. So I was given the F grade, and I felt that I was given the F grade because I was being discriminated against. But I probably would [...?...] a bit. They said not. But I felt very strongly and I did appeal against my grade. And then unfortunately, when the letter was sent out to me I was under the impression that you had a certain time to reply to this appeal - if not, it would have been forgotten about. And I was in Barbados on a holiday when my letter came. By the time I came back it was... the date had passed. So... that was that. So, I mean, I carried on. I thought... you know. I was annoyed with her at first, and then I thought, well, it wasn't her fault. It was the system and the people at the top. So then everything went back to normal. But then, with all the cutbacks, our hospital became a Trust. All the cutbacks, and they were closing wards and all kinds of horrible things, cutting back on domestic staff, the hospital was dirty and not enough staff. The atmosphere, morale... My friend Peggy she's in the... she's the union rep and I spoke to her, I said, you know, if they... I said I'm really fed up, you know. The other sister, Eve, wasn't pulling her weight, and they closed the ward. And they brought another sister on the ward. At first they said they couldn't have two G grade sisters on the ward, and then they were creating a situation where there were two Gs and an F sister on one ward. So I really got fed up. I'd just had enough of it. So I said to her, have a word, you know, and I spoke to the Nurse Manager, and I said if they would offer redundancy comes at that time

-they weren't. A year... a year ago - year-and-a-half ago -they weren't thinking very much about it. Not in our hospital. It became a Trust, and they thought about it and they said was I sure, cos I'd been there for eighteen years, blah blah. And they, you know, put everything to me and I decided yes, well, if the offer's right - reasonable - then I'd go I'm still young enough to get another job somewhere. So I decided yes, well, and I got it. And I left. And I've been working as a sister in a nursing home. But now - for five weeks now - I'm a practice nurse for a GP.

JH Oh, are you? Are you enjoying that?

G Yes. I like that.

JH My sister's a practice nurse.

G I like that.

JH Yeah. Yeah. Well maybe, sometimes a change is good.

G Change is good. I mean, I know all there is to know about gynae.

JH Sure.

G I do. I'm going to have a rest from the National Health Service. [...?...], cos it's just terrible. It's not the same.

JH No. No. And do you think within that that people like yourself have been treated worse because of their colour than other people? I mean, do you think there was...?

G Oh yes, definitely. Definitely.

JH And a lot of people haven't got what they should have got?

G Exactly. True. I mean, all...

JH I remember reading a report into this in the Nursing Times.

G All the... I mean, at that hospital - at St. Mary's - the Enrolled nurses on night duty were all given D grades - all of them. And most of them were black. And then... a few of them were white, and two of the white girls appealed. And you know this appeal system took ages to come through anyway. They won their appeal, the two white girls, and were upgraded to Es. And that caused a lot of controversy, because all the others were saying: "we all do the same work, so if they can get Es then we have to get Es". So then they had to upgrade all of them. But then they didn't get any back-pay. The two white girls got the back-pay cos they appealed, but the others didn't. So I mean the grading system - it's a good idea, and it would have been a marvellous idea if it had been carried out properly. But it was so unfair.

JH It was definitely used, I think, to get rid of people.

G Definitely.

JH And what about... have you felt over the period you've been a nurse, that your own position, your own view of the profession has changed a lot? Or do you think it's maybe pressure from, you know, the health service that's changed a lot?

G The pressure from the health service - definitely changed a lot.

JH And that's...?

G The government's policies.

JH Yeah. Do you think that's put a lot of pressure on nursing?

G It has. It has. It has a lot. I don't think a lot of people will be interested in nursing, you know, all these aspects at all.

JH I mean, if you had a daughter would you be recommending her to...

- G No, not now. No. Nursing's not the same. Not in the hospitals anyway.
- JH And how do you think the public see nurses now?
- G Well... the public still love them I think. They still see them as angels. I don't think, whatever happened, I think that would be the general opinion. But that's just my opinion. Because I know everywhere, everybody all, you know, patients and the relatives there, you know, say 'they never pay you nurses enough'. That's all they ever say because they come in and they come to visit their relatives, and the patients themselves, they see you rushing around cos you're short-staffed. I mean, they're going to think you're really an angel because you're going to do your best for them. No matter how stressed out you are. You know, you will always do your work. So...
- JH Did you find it very stressful? I mean, was it that it got a lot more stressful, cos you were in a position with a lot of responsibility?
- G It did. It got more stressful.
- JH And in a way, you were at the point at which I would have thought the pressure was most acute, because once you're management, the pressures are different.
- G Exactly.
- JH And sisters, in a way, I think, are very much on the front line.
- G That's right. They have. They have a lot of pressure. You know, the various changes. So many things that... I mean, courses for example, in our Health Authority, you had to be up-to-date cos it's a teaching hospital with student nurses. We all had to be mentors. We all had to be assessors. You know, everything continuous, you know. All the changes and yet you were

expected to carry on just the same.

JH And did they give you time to keep up to date? Did they give you days for study-leave, or...?

G Well we had... Yeah, you could have study-leave if you wanted, but then things got tight when they became a Trust because... before [...?...] you could take study-leave for any particular thing that you wanted; then they were being choosy, you know, how much money they've got to spend. Everything was, you know, focusing on the money, you know that they've got to spend, so...

JH And did that affect patient care a lot, do you think? I don't mean nursing care particularly but just the general sort of experience that patients had.

G Yes I think, you know, there were more complaints from patients. Food was paltry. You know, they started this cook-chill business...

JH Small [...?...].

G Horrible. And that was terrible. Patients were complaining their food was shocking, and the wards weren't clean because they'd cut back on domestic and cleaning staff. And the ward was terrible, though I say so myself. Cos at first there were three domestics and they cut them down to one. I mean, they expected one person to do the same work that three people used to do. Impossible.

JH That's how things get to... What about Project 2000? I mean, have you heard anything about that? Or had to train anybody associated with that?

G Er, no. I wasn't involved in anyone in that aspect up until I left. I suppose if I was still there, it's starting off now, isn't it?

JH Yeah. What did you think of that?



G I don't really know because that involved people who weren't properly trained being at the patient's bedside, didn't it? And I wasn't too sure about that one at all. I wasn't too sure about it, no. I never really paid much attention to it. I know, in the end, I would have had to, you know, be involved with it all but... I didn't like the idea.

JH Do you think it's good for nurses to be educated in college? What do you think? I mean, just in terms of the balance that's needed. Cos you would have been educated probably like me...

G Yeah.

JH ... which was on the block system for six weeks at college and a lot of time on the wards, whereas my sister was educated the other way round. She's always said it gave her no confidence. I just wondered if you had any experiences.

G Yes I've had experience cos we used to have the bachelor nurses on our ward, and I found that they were very intelligent girls but had no kind of theoretical common sense, because some of them were in their third, fourth year when they came to us, and there were a lot of procedures on the ward that they weren't familiar with and couldn't do. I mean, girls nursing on the ward, like with the old system - the girls were efficient. You know, in your second year going into school, going into blocks and all that, and they were efficient. That's what nursing is all about, I think.

[END]

LY Came to Britain to complete her schooling and train as a nurse in the mid 1960s. She commenced pupil nurse training at a municipal hospital in the late 'sixties; after qualification she worked for sixteen years on a special care baby unit. She then upgraded her qualification to SRN and is now a staff nurse on a surgical ward.

LY Well, I guess the first images I had of nursing was from my godmother. She was the midwife, and I believe she delivered me when I was born. She was a very bubbly and loving type of person so she would always come around and see you from time to time and I would see her walk in with this crisp you know white apron and a little like straw basket over her arm and just go round the village visiting people and you know looking at the children. And there used to always be lots of children running around her and she used to always have sweets and things in this basket giving to people and ah I remember I used to be always be quite proud of her, that she was my godmother, and where ever I'd see her, say like if I was on the school bus or anywhere like that I would say 'oh look' to my friends you know 'that's my godmother and she's the midwife', that she delivered me and things like that. So I suppose that was my first images, yes, my first influence of nursing that I had,

JH Other influences...stories, books, things like that...

LY Not really, no no, I suppose it was something innate. I always wanted to be either a teacher or a nurse and I chose nursing here, but I guess if I had been in Barbados I would have been teaching, teaching because it's more or less like second nature to me as well. I used to like teaching but I don't seem to

Makes me shudder when I think about it now and then we'd bury them in little matchboxes you know (laughs) I can't remember but she said you you used to always touch the dead lizards and put them in boxes and um then we used to bury them. But I was never really scared of them to any extent.

JH Other reasons for becoming a nurse, like being an air hostess?

LY No, I just wanted to become a nurse and um that was it.

JH How in a practical sense did you become one?

LY Um. no, I applied to the hospital when I was um 16 and started um I could've... This was yes in the 'sixties, um sixty seven it would have been when I applied so I would've started in sixty eight. I started in 68 but I started before, yes, no in 68 I would've been 18 to start my training but I was so eager to go in, I didn't go in as a cadet um my mum didn't want me to go in as a cadet because the hospital I got into to start nursing as a cadet was in Rochdale and it was quite a way to travel. In those days I didn't have a car and its little birds knowing and things like that so my mum sort of put me off from there but I did get in at Oldham hospital to start my training so I went to them and I said I really wanted to start my training so I started...In those days, they used to start you as a pre-pupil so I started like 6 months before the school was due and (I think that would have been like the November/ December) and then the actual course started in the April of the following year, so I did like 6 months as a pre-student, just getting used to the wards and things like that. They were so short of staff then that I even did like a week on nights to help out then, and I was like seventeen and a half. Ummm.

- JH What did friends and relatives think?
- LY Well, in those days really it was the thing for a lot of people to do nursing, so I don't think there was much of a uh there were much joy bout it really, it was just like uh the norm.
- JH Were they proud of you?
- LY Oh yes, yes, because my mum was doing nursing then, she was still you know working as a nursing auxiliary um because because she didn't do her training because of the children, so I just went into nursing and it was just like the norm you know, nothing about it then, you know.
- JH Did you ever do anything else workwise?
- LY Oh well, um before before I started as a pre-student, when I finished school for the six months before I started.. I worked as a machinist in um uh making children's vests and that, a children's firm. But I didn't really like it, I still wanted to be a nurse you know, and um that's when I went to the hospital and that you know, to see if I could start a bit earlier, and they said oh yes you can start as a pre-student for six months, I didn't work there for very long.
- JH How did you choose the hospital?
- LY Well, you used to you mainly used the one in your catchment area really. So Oldham, we lived in Oldham so we tried Oldham Hospital and then the next neighbouring one was Rochdale which was Birch Hill Hospital but that was quite a way to travel.
- JH Was it through your Mum?
- LY She was already at Oldham hospital, I think I just wrote to them and asked them if there were any vacancies for nurses. It was quite easy to, get on then,

you know you should go in and interview and do a test and that and they would just take you you know.

JH What did it feel like when you put your uniform on and started being trained).

LY That take me back a while, I can't remember. Um, I can't remember really, I suppose I felt quite proud because in those days the nursing uniform was something to wear, they used to starch all your pinnies and your dresses and your cuffs and things like that you know, and your collars, yeh, and your caps so that when you put those on you feel you know quite important really, but uh and these days it don't really mean anything, its just..(pause).

JH Did you live in?

LY No because I was living quite near.

JH Were there lots of rules? Did it seem very strict?

LY Oh yes, it was very strict. The sisters in those days were quite strict, they used to put the fear of god into you, you know and when you go on the ward you see a sister, you stand and in this day and age, they don't have to do that they had great respect for the sisters, the old regimental ones used to put the fear of god into you.

JH Do you remember your training being hard work?

LY No, I don't remember it being really hard work then because I was younger then and more receptive weren't I, so and I just finished school so it...it was quite easy, I found it quite easy, I find studying now harder than I did than, it was just...

JH Did particular people make a significant impresson on you? Were there any nurses you admired?

having a bath today" they just go along and have a bath or whatever but in this day and age its "Oh no, I'm not having a bath today" and there's nothing you can do to make them have a bath, they've got the choice to say no.

JH During your training - did you have a good social life?

LY Oh yes because in those days a lot of nurses used to come over from the West Indies to do their training so um I had quite a health social life with my friends and there was girls from Jamaica, Trinidad, Bermuda and there were lots of colleagues from Mauritius so we used to you know and the classes they were quite big, about 32 and there were people from lots of the Caribbean Islands and that so it was, you know, quite interesting.

JH How many intakes?

LY I think they used to have about 3 a year yeah.

JH And was it mainly women, or men as well?

LY Majority was women, but there were some men. The men were from Mauritius yeh - in the classes maybe two or three. There weren't a lot of English men, I find that um there are a lot of them now but before they weren't really interested in it.

JH Unemployment has done a lot for it. Do you remember at that time anything enrolled about nurses or TV or things in the media? Late sixties pay campaign?

LY I can't remember it, I can't remember really. I daresay I wasn't interested in that then. But nurses pay was certainly nothing to write home to mother about it was terrible and working conditions, when you were training, you would do as you were told and the hours the lates, you used to have to work

your social life around what off-duty you had.

JH What kinds of hours did you work? Split shifts?

LY These were terrible. You would do 8-1 and then you'd go back and do 4-9 or something like that.

JH And when you were on nights?

LY 8 till 8, sometimes up to 6 nights a week. And sometimes it would tag on, four for one week and another four for the next, rather than a three. It could happen you get the two fours together so you end up doing a full long week of nights and it used to be really terrible, very tiring.

JH Were you often in charge or on you own?

LY Yes, as a student I was left in charge quite a lot of the time. But you used to just take it in your stride, you know, you didn't know any different, you just had to say yes to everything. But students today would not... wouldn't do that they'll question it. We didn't realise what kind of responsibility we were taking on, and we would just um do it.

JH Do you ever remember being frightened?

LY Oh yes, yeah. I was frightened about a lot of things, I remember being frightened really about you know the night, about night duty and just walking around seeing everyone asleep they used to look such deathly white and from time to time your heart would miss a beat and you'd think are they alive or dead. It was really frightening. In the night people looked worse than in daylight. I found that frightening. And I got attached to one little lady as well, and you know, when she died, that was...I've never been actually frightened, but that was frightening for me because uh I still used to see her

I had that image of her face in front of me. Even at home, would just see this little old lady, Mrs Trueman she was called, we used to call her granny (quiet) Trueman and that memory of her used to stick in my imagination.

JH Was there anyone to talk to about what worried and frightened you?

LY Not at all, no-one no. There weren't much support for nurses at all people were very hard and cold towards it, you just do it, and get on with it and that, that was it. I remember though there was one uh Sister that once we had a patient who was quite poorly and uh they were haemorrhaging and we were pumping blood um and it were coming out their other end and it was really frightening and she gave us quite a lot of support then. And another time when we had was it the German flue, or something there was a flue going around in the seventies and people were dying like flies, you would walk down the ward and there was a dead body, and more on another one, and I remember that the mortuary was so full that there was a portacabin to put these bodies in. And um, that was the only time throughout my nursing training that we got support from one of the senior sisters, who realised that there was so much death around, it was having an impact on the nurses. She would just say well it was something that happen and don't take it on, I try and relax about it.

JH Did you nurse a lot of elderly people?

LY In those days foreign nurses as well were placed mainly on the geriatric wards, yeh.

JH Was that particularly difficult? Did you feel you were being pushed aside.

LY Exploited? I felt that because I did my SEN training first like I said, and



mainly students - pupils as they were called in those days were placed in the Geriatric Wards. Students would do the majority of the general nursing, so you would find that you were always -you were mainly - the caring type of nurses rather than the specialised type, you know. You would do some training in surgery and theatre, but not the majority, the majority of the time was spent on the Geriatric wards.

JH And is that were the majority of jobs were?

LY For enrolled nurses, yes. There were a few jobs on the general side but the majority were on the Geriatric Wards. That's why, when they did the re-grading, the majority of nurses that were on the Geriatric Wards got good grades because they were there all the time being in charge and then there was an outcry that oh they've got this grade, they got E grades but they were in fact doing the brunt of the work and being in charge. So they deserved it really, it was a form of being exploited, but grading did some good for the ones that were left on the Geriatric Wards and were exploited because they got the grade they rightly deserved.

JH Did you still find that the management was very white?

LY Oh yes, yeah it was. Not many people got into management. Not many, and even to this day you know it's still very white very very. It's really hard to move up, you know the ladder.

JH It seems to still be very disproportionate...

LY Oh yes, yeh. I think really that black nurses realised that this was happening and that they weren't getting any where fast and they opted out. I notice that there aren't as many in nursing and as a matter of fact it's changed where the

white girls weren't at all interested in nursing, they're in and the proportion has changed, whereas before there was large amount of Black, minimal amount of white. It would be after the seventies yeah that the trend changes, all the unemployment and strikes and the teachers strikes aha brought a lot of people into nursing, people with degrees who were teaching and there weren't any jobs, it was an easy way, they had the qualifications and could get into nursing and they did the nursing training some of them just as an option really, just to get a job, and some stayed and others just went on and eventually when there was a break for them in teaching they went back into teaching and pushed on with their career.

JH Same problems with patient as with management? Were they antagonistic?

LY Some were, yeh, you get it in every area really, you got some that were really antagonistic and um you know, they would sort of tell you to get back where you came from and things like that and others you know weren't. I found that if you met people sort of that had never been anywhere that don't even know the history or the geography of the World you know "which part of Africa are you from", they tend to think that every black person although we originally came from Africa not necessarily live there now, seemed to think that every black person um lived in Africa.

JH Any sort of ceremony at end of training?

LY Um, yes we did - I have a picture somewhere of that, we used to have a graduation ceremony where you get your certificate and bring your relatives in for a drink afterwards and meet your tutors and things like that.

JH Did you have to wear a special uniform?

LY Just wear our uniform and caps and that, but nothing special. Ours were just cotton caps that sit on top of your head.

JH After [...?...] working on the wards.

LY I didn't work on the Geriatric Wards that much after I finished my training no, I got a job on the Gynae Ward, which was lucky for me cause I like Gynae and I always wanted to do my midwifery so I worked on the Gynae Ward for about 6 months to a year and then went on to the Prem Baby Unit to do the course so I thought that would give me an insight into maternity and I did the premature baby course, a short introductory course between 6 and 9 months it was so I thought after that I do my midwifery but unfortunately I became pregnant with Damien then and family life took over. So I worked on the prem unit then for 16 years and of course being married and having a family, I found that nights was the best thing so I stayed on nights and just did some nights on the unit and then sometimes I would work on the Maternity Ward in the nursery and I stayed on the prem unit for 16 years and then I went and did general nursing after that and now I specialise on the surgical ward.

JH Re-grading - Did it make a difference to your job?

LY No, it made a difference to the salary. They weren't grading you, as a person, they were just grading your job.

JH Do you think your view of nursing has changed much over the years?

LY It has really because all the aspiration I had in nursing, I still feel that I haven't fulfilled them because of all the stipulations in nursing, it's still really difficult to move on from one thing to another, and it seems as well, I mean

I'm the last person to have a chip on my shoulder but it seems that once you are black, it's ten times harder to move. Yes. But of course, I had quite a long break because I had the children and I couldn't do anything. But once they were grown up, I felt more motivated but I seemed to get frustrated because I can't get anywhere and these days now everybody's holding onto their posts, it's like dead man's shoes, nobodys moving from our area to another. If they've got a good grade, they just stay there unless you get somebody moving away from that hospital. You can move around, but it's difficult if you've got a home and family, it's not that easy to do. But within your own hospital, it's very very difficult. People aren't changing jobs like they used to. There's so much competition, you know there might be an F grade post going but there would be like 50 and 20 from elsewhere going for it.

JH Do you think the image of nursing today is very different?

LY Oh yes, it is yes.

JH What's that to do with - the job? Or changes outside nursing like education, political things.

LY Nursing isn't very different, nursing is more or less the same but I think all the changes and influences come in from the political side and education for the simple reason people come into hospital for an operation and won't have a clue where the gall bladder is and what it does or anything like that but in this day and age people have been educated and then, so they'll be telling you what's happening to their body rather than asking you, you you're just a support for them to allay some of the fears, put them right where they're

wrong but some of of them have a good basic knowledge of how the body works really and they're um they're educated so much more healthwise um they're taught a lot more what to expect when they come into hospital as well. Before, years ago, you'd just go to a patient and tell them they're having so and so. They come into hospital and they're really nervous. We ourselves weren't educated in the sense to see people that are stressed, were really anxious and body language and things like that, but in this day and age you are taught and that's got a lot to do with things.

JH And what do you think about Casualty? Do you ever watch it?

LY I think it's very realistic, I think it is, it's very realistic.

JH Does it give you a good feeling about your work when you watch it?

LY Yes, it does, yes. You feel it values what you do, yes.

JH What do you think about a move to a college based education?

LY I think the move isn't very practical for the simple reason that student nurses who are at the beginning of their training have done the theory before the practical. When they come on the wards they're still really very scared of situations because of actually being with patients and the problems is then valuing the problem they had in the classroom and it's difficult for them, you know, to put the two together initially although they're got it, the basic idea, in theory it's still more difficult than if they'd been on the ward on a practical basis during the first 6 months of the training. Project 2000 - Is it very centred around graded training, part 1, part 2 etc. Well you can start from a lower basis can't you, you can do your basic training and get credits and build yourself up, then eventually up to a degree and as a matter of fact I

think the RGN training will be an outdated thing because the nurses with the degree course will be more recognisable than the RGNs who've done the basic nursing training well, the general nursing training before.

JH I remember you saying before the problem with this is that it's on the individual, you don't get much support like days off for study leave or anything.

LY It's up to you really to fit it in and do it, which means that you could be moving away from your complete home environment to whatever college offers the better facilities or whichever hospital would sponsor you to do it. So it's not necessarily that you're going to get the *best offers from your* hospital that you're at. If you've got a family, you could be quite restricted though the majority of nurses if they're young and single um they'll do that but I mean you'll find that from the statistics Britain are losing a lot of nurses to USA and Germany and Florida where the pay is a lot more than what they get here.

JH So do you think it's a less attractive career for women now?

LY Yes, nursing as it is now is itself less attractive, but if they're moving into management, some people will come into it and just train as the basic thing and then go into management and specialise in any of the off-shoot areas from nursing, like health promotion, like breast care, you know, just being an advisor that you know specialising in diabetes as an agent for that, breast care um specialist courses, things like that. Pain control nurses, you know.

JH And how do nurses train for the specialised areas?

LY There are just courses that's offered. The hospital can sponsor for these

courses or you can pay for them, be seconded by your hospital and pay yourself, different colleges do them. And they can be quite difficult to get onto as well because you've got to be responsible for your own training and update yourself, but it still boils down to money and your hospital won't necessarily pay for you to do the course, so if you really want to do it, and now nurses have got to have a record of recent study to re-register now, with the UKCC every 3 years you have to have evidence of at least 3 study days a year so if you don't make it your interest, which means you might have to move away or pay for the course yourself you won't be able to register to have your PIN no to practice as a nurse. You've got a record book and um whenever you've done a course or anything it's entered and stamped and signed by the course tutor or whoever. A lot of the ENB courses are university courses, open university do them. If you've got the extra post-basic post nursing training and you apply for more jobs, you've a better chance of getting it especially if it's in a specialised area. Say your're working on Casualty and you've done an A. & E. course, or counselling course the fact you're dealing with the public, counselling skills would be an advantage to have and A. & E. care would be quite an advantage to have, so if I just have an RGN and apply for the course obviously the person with extra post-basic nursing qualification would pip me at the post so it's more competitive and does not necessarily pay better. Unless you move into management - it's up from Sister grade you get the highest money. You become stagnated in the end, all the things you really want t do, you find that you're limited and more or less you have to keep your job and stay in it. Before it was a specialised

area you liked, you could move on and do it, now you're not going to get it so if you've a family you stay in the job mainly for the money but it's not necessarily what you want to do in the area that you really like.

JH Has your uniform changed over the years?

LY Yes, it's horrible now. The girls in Littlewoods dress better than nurses today. There's not much pride in it and uh... But I think really a lot of hospitals have realised this and are doing you know the BSC standard kite sign, quite a lot are raising standards, a lot of nursing care and nursing attitudes they just set certain standards to make sure that people work within those standards but it, I mean, they tend to look tidy with what they have but it's nothing like what it used to be.

JH Do you still get laundry done?

LY Yeah, but a lot of people don't tend to use it because you never get them back. They're always astray, so people tend to do their own washing.

JH So do you think working conditions have improved?

LY Not necessarily, no, we don't have proper changing rooms, they're worse than they used to be. They're just tiny little rooms on the wards, no proper facilities for the nurses even in eating. You can use machines or the restaurant, or bring your own. There's a lot of emphasis now on healthy eating, salads, vegetarian diets and things like that.



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M came to Britain to train as a nurse in the early 1960s but failed to secure a training place. She started working as an auxiliary nurse in the early 1970s.

M Well, my name is M... H... and I've worked in the hospital for... [cut]

[TAPE BLANK]

M ... which is quite good, but I enjoyed. You know, so...

JH I want to ask you now, why did you become a nurse in the first place? Can you remember?

M Well, erm... From an early age, I never wanted to be a nurse. I wanted to be a children's nanny. That's what I wanted to do. And when I got to sixteen, my auntie, who looked after me for a long while, she had a brain tumour and she went to America to have it done. And when she came back she was like a little baby. She wanted all the nursing you could think about. And we weren't... you weren't rich or you weren't... had enough money that you could employ a private nurse so everybody had to rally round and looked after her. So I started spoon-feeding her, bathing her, everything she wanted we did at home. And then, two years later, my boyfriend came to England and he wanted me to come. So I followed on after that, and when I got here I went to the cotton-mills, the cake factories...

JH Did you come to Oldham?

M No. I didn't come to Oldham. I came to Kent.

JH You came to Kent?

M Yes. I worked in Kent for a few months at a golf-course. And then he wanted to get married so I moved from Kent to Oldham, and I had all the

different jobs like working at the cake factory, clothes factory... And then the kids came along so I had to find something else then to fill in that space, whereby I could look after them as well as work. So I move into the hospital then. And... it's completely different to what it was then, because... talk about primitive. They thought that we - West Indian - were primitive, but when I came to the hospital it was more primitive than what we had, because the floors were just pine floors and patients were incontinent and, you was an auxiliary, people used to look down their nose at an auxiliary because she had to be cleaning up the floors after the patients, and all the mess and what have you. But erm... it's got better now.

JH [...?...]

M Yes. Because it was shocking at the beginning.

JH So did you... when you went home, did you know anybody who was nursing at home?

M My aunt was a nurse.

JH Your aunt was a nurse?

M Yes, she worked in the General Hospital at home.

JH Right. So you had a knowledge of hospitals...

M Yes.

JH ... Before you came. And what was the hospital like at home?

M Well, it was a general hospital and all sorts went on. If you had money, you could pay for what you want. And if you didn't, you had to wait on the list like everybody else. You know.

JH Yes.

M And... what I still think the nurses there were... They were proud. They were proud girls to be nurses. Anybody who got into the nursing profession there were more or less respected, and they were proud. You know? And erm...

JH And yet they weren't...

M She earned... Full uniform and they still do now, they still d... I mean, England has changed the uniform so many time, but there still you wear a uniform. Yeah.

JH Can you remember what the uniform was like?

M Well for the private nurses, they were white uniforms and white shoes and a white cap. And the other nurses had different colours because of the different year in training.

JH Oh right. So similar...

M Similar to here, yes. But they wore full uniform.

JH Did they wear special hats?

M Just the ordinary caps that they wore, yes. Only, the only matron wore something different.

JH And was this St. Thomas? Are you from St. Thomas, or from Jamaica or...

M No, I'm from Barbados.

JH Oh, you're from Barbados, that's right.

M I'm from Barbados, yes.

JH So... Right, so... Yes. So was there one big hospital in Barbados?

M No, one big hospital and... which was the General, and then they had a lot of cottage hospitals around. And we used to call them the almhouses, where

little minor cases went. If you had a cut foot, if you had... you had sores or any minor things that need to go to the hospital, you could stay in your own district, because there were parishes and it was like... Oldham and Failsworth and all those little things, inside of Greater Manchester. So we had... for each one we had a cottage hospital, you see. We call them cottage hospitals now. And they're all upgraded now, so a lot of things can go on there, rather than going to the General Hospital, you see.

JH So you had a lot of knowledge [...?...] about nursing...

M Oh yes.

JH Before you came to...

M Yes.

JH ...England? When you got to England, how did you come to get your job as a nurse? Did you have to write to hospitals, or...?

M Yes, because at the time - that was in the early 'sixties, I came - but before that the government at home was sending nurses - girls - up to England to do their training, with the expectation that they'll come back home with what knowledge they'd know here and pass it on there. Well, that didn't work out very well because a lot of nurses came and didn't go back, you see. And... I wrote to hospitals before I got here to actually do my training...

JH Did you?

M Yes. And then, they didn't have any vacancies to the hospitals I wanted. So when I got here, instead of going and doing exactly that, I went the opposite way, and then I got married and, like I said, the children came along. And I applied because the hours suited me, and which I could work from eight in

the morning till one in the afternoon. So those hours suited me with the children. And then it moved from there on to night, because the pay was... it was poor but then a pound was a lot of money, so I move on to night duty. And I stayed there ever since.

JH So when did you start? Twenty years ago, you say you first started.

M Yes, erm...

JH Was that 'seventy-two?

M Er..., 'seventy-two? Yes, 'seventy-two. Yes. Yes, I started in 'seventy-two, yes.

JH And when you started, did you know anything about Mary Seacole or... - the Jamaican nurse who went to the Crimean War? I only ask because a lot of people don't know about her and...

M No, I...

JH ... nobody knows much about her.

M No, I don't know anything about her, no.

JH No. No. Because, there was... I mean, this is partly what I've been doing. There were three people who went to the Crimean War and who all later had books written about their experience, and everybody tends to know Florence Nightingale...

M Yes, I'm familiar with Florence Nightingale, yes.

JH But nobody knows much Mary Seacole...

M No.

JH ... who was from Jamaica, who when... she came to Britain and tried to go in fact with Nightingale, and wasn't accepted. And went separately on her

own, set up a first aid station and a boarding house. And there was another woman who went with Florence Nightingale, a woman called Elizabeth Davids, who was from the Welsh valleys, who was a very working class woman who went. But that's partly... I've been looking at stories about them. You know, it's just... So, you've heard of Florence Nightingale...?

M Yes.

JH How did you hear of her? Can you remember?

M I think I just heard it in passing and then, as time went on, you realise who Florence Nightingale was. And she appeared on one of the notes, the money, that we have. And then you realise then who Florence Nightingale... But I think... I think we did do a bit about Florence Nightingale at school, you know. About nursing, yeah, looking back.

JH Yeah. Yeah, so it's... Did you have any knowledge of nurses from books and radios at all, as well, in Barbados? Was she... was a nurse like a popular figure that you might see stories about in a magazine or something like that?

M Who are you speaking about?

JH Any nurse.

M Any nurse?

JH You know like nursing stories, or nursing romance stories.

M Oh, romance stories, yes.

JH ... That kind of thing. Do you have those in Barbados in magazines...

M Yeah, and you could go to the library and get those.

JH Were you ever into those? Did you ever read those much?

M Yes, one or two, yes. I think every young girl...

JH ... lots of girls do.

M ... every young girl reads a nurse and doctor storybook. Everyone does.

JH Did you like it? Did you find it a romantic image?

M Yes, and it painted a completely different image in the book than what in reality it is. I suppose they could make it up to make it ever so romantic and nice whereby it is not that way in reality, if you go through it, you know?

JH So how did you feel when you got on the ward and you were on your first day? What happened on your first day? Did you have to go to the hospital and they put you in [...?...] or...

M Well, you had to go for a medical first.

JH Right.

M And after your medical, they send you to the sewing room where they kit you out with your uniform and your buttons and your apron and your cap. And then they tell you you have to wear less shoes and stockings or tights, whatever. And the first day I arrived at the hospital, I was lost. Really lost because I have an idea of what goes on in a hospital, but when you're actually on a ward where there's twenty-six patients and you find patients who are CVAs where they can't move a leg or an arm, and you're trying to dress them. And you're sweating. It's taking all your time to get the arm move, and you're thinking I'm hurting this person. And you're struggling, and there's nothing they can do to help you. And you have to just struggle on on your own. I mean, then, nobody wanted to work on geriatrics, nobody. Nobody. And I think, when... coming to England, going to the hospital, they wanted people to work on the geriatrics. So... And if you... And they put

you on geriatrics, and you could cope with the geriatrics, you can cope anywhere else in the hospital. And that's what happened. I arrive on the ward, and there was an SEN - two - and they were in charge of fifty-two patients and you had to run between the two. You had to do one shift on there, whereby you were doing a bat round. And when I say a bat round, I mean a bat round, because every patient needs seeing to. And then when you've finished there you go on the other side and you do exactly the same. So when after coming... after finishing there, you were no use to nobody after, because you were that tired, yes. Yep.

JH And it's more than just the physical exhaustion, as well, wasn't it? I mean, do you remember feeling scared or things like that, or tired, when you started anyway?

M Yes. I was scared, thinking how am I going to cope with all that this is in front of me? Because you never stop, you never stop. And the SENs that were there - some of them were not trained SENs, they were there for a length of time, and they made them up as SEN because they thought they had experience enough to cope with a geriatric ward. Cos they couldn't go on another ward anywhere else in the hospital. They had to just stay on geriatric. But they were good because all what they knew, they passed on to us.

JH So you did get some training?

M Oh, yes. Cos I never... I never tested a urine before. And, going on, they taught you how to test a urine and how to take a temperature and things like that. So you had, from the beginning... When, after three weeks, and you



were... they thought you were in. That was it. If you wanted to know anything, you have to catch it in passing, or watch and pick it up as you went along. And if... in all that time, they were monitoring you, as you would say, and if you're picking it up, well they pass it on that you were OK because they were going to assess you after three months.

JH Right. So you got assessed?

M Yes. You got assessed after three months.

JH And what was that like, the assessment? Can you remember?

M Well, they ask if you like the job, and if you were coping, and if you would like to do your training. And, I was ready for doing it but, when I think of the children, I didn't, you see. And that's why I didn't do my... But I think they were... the nurses then were kinder and more loving towards one another, and the patients, than they are now.

JH So you found that fairly supportive...

M Yes.

JH ... and the people taught you things...

M Yes.

JH ... and then you weren't treated too badly as an auxiliary?

M No, I don't think I was, no. I wouldn't say that I was.

JH And were they... were they white women that were teaching?

M Yes.

JH And yet they were OK?

M They were OK, yes.

JH Yeah. That's quite interesting. So, once you started off and you were

working, and you had this very busy schedule, did you then stay at... you say you were there for twenty years? In the same ward or...?

M Eighteen years I was on the geriatric wards. There were nine geriatric wards, and you were based... You weren't based on just one particular one, you were moved about. From week to week, you went on different wards.

JH Right. Is that good, do you think? To be moved about.

M We tried to tell them that it wasn't, for the patients sake. But they still do it. And it's only now that they decided not to put you from ward to ward, to put you permanently-based on a ward. And those patients are better because they get familiar with a face all the time. Yeah?

JH And what were the patients like? Did you find them, on the whole, sort of fairly pleasant. Or were they too...? Were they psycho-geriatrics? Were they inclined to be a bit loopy?

M Yes. On a ward you could get about half-a-dozen that were - I won't say 'loopy' - but they don't know where they are or what they're doing. And then you get some that are very roisterous and they call you all sorts. And you just put it down to the patient. It's the patient, so to me if they say anything, they are the patients. You take no notice, you know.

JH And that was all right?

M That was OK.

JH And did you have other friends in the hospital, to support you at work?

M Oh yeah, there were quite a lot of coloured girls there.

JH Yeah. So you didn't feel too then that you were isolated.

M No I wasn't feel out of place either, no.

- JH Yeah. So it's better, maybe, than the experience that some other people can maybe work[?]? You're not isolated...
- M Yeah, some were isolated but I wasn't.
- JH ... You were in a fairly good environment. So, going to work wasn't too bad in some ways? Did you enjoy your work? You did it for a long time.
- M Sometimes I did and other times I didn't. Because when you were going to be left on your own - cos we were left on our own quite a lot - and when you were left on your own, and you have all these patients to see to, this is working night, night-time. And there were two wards, and you were based on one ward - say, the A ward - and somebody else is on the B ward. And if you have a look, you will find someone in between to come and give you a hand. You never got a dinner-hour, because there were no staff at all. And that's when it was hard because you could only do so much. And that's when I became isolated, and fear of going to work, because you know that when you get there, you're going to be left on your own all night.
- JH And did that happen for a long time?
- M Oh yes. Yes. A long time. And I used to complain to my husband every night, every morning I go in. And he said: "well, Muriel, why don't you leave the job?" But then when I thought of the kids, then, if I paid out money to look after them, I might as well stay at home. Cos I wouldn't be bringing home anything. So I chose to stay.
- JH And was there any union, or anyone that you could talk to about those problems?
- M We always talked to... The union only came about, for me, about nineteen-

seventy... four, seventy-five, the union came about. Because we had a coloured bloke who came working at the hospital, and he was a charge-nurse, and he started up the union. Well, there might have been a union before, but nobody came to us. But this bloke came along, and he ask if we're in a union and we said no. And right there and then he recruit us up as members, you know. So the union came along then. And it was only when the union came along that staff begin to on the increase.

JH And did he manage to do anything about...? Well, he must have done...

M Yes.

JH ... because you say...

M Staff start coming about, yes. And things got better. And now you're not left on your own. You're not.

JH Well, that's quite interesting. But you didn't know anything about the union...

M No.

JH ... until this guy...?

M Until this guy came along, nobody told us anything about the union.

JH And was he in geriatrics too?

M Yeah, he was on a geriatric area.

JH Yeah. But he was trained, was he?

M He was trained, yes.

JH He was in charge, yeah?

M He was in charge, yes.

JH And what were the management like? How did you find the management

generally?

M Well, to be critical of my boss, she was horrid. She made you feel so belittle and... she was horrid. Just her presence used to make you feel uneasy. Now, the matron was completely different - because when I came, there was a matron. But she was the number seven. She was a horrible woman. I'm sorry to say, but she was horrible.

JH Well some people are.

M She was horrible. She made nurses cry, you know, because of her attitude and her mannerism. She was horrid.

JH Do you think she was racist, or was she horrid to everybody?

M Well, there was some of the nurses...

[PHONE RINGS]

JH OK, so you were talking about this nursing officer.

M Yes. She wasn't nice at all. I never liked this woman. And there was... not that I didn't like her, a lot of the girls didn't, 'specially the coloured girls. Because she had one group of girls which was white girls, that she would laugh and joke around the trolley when she was doing anything. But when it came to us, she always find fault about something. She always pick, pick, pick on us. Yes? And, I know I'm an auxiliary, but she made me feel worse. I know I'm lower down the scale, but she made me feel so... oh... She wasn't nice at all. No.

JH And did she leave or...?

M Yeah. No, she left. She left. And I've never had the problem since. I get along with all the others, but just this woman, she... ooh, she was horrible.

JH Well, what about doctors and things? Do you have much contact with doctors?

M Oh yes, sometimes you help the doctors with a patient. They examining a patient, you go in with the doctor and he tells you what he want. And you do accordingly. And if you don't know, some of them will tell you what they want properly. Others will look at you and think, well, you don't know what I'm talking about so I'll get somebody else, you know? But it never bothered me.

JH Did you ever have any idea that you would go and train? Did you have that as an ambition throughout this time? Did you ever think oh, well, when the kids are older or whatever?

M Yes. When my daughter was fourteen - thirteen, sorry - I... One of the auxiliaries that were there was an ex-policewoman, and she got to together and said, she said: "Muriel, you can do your training. I'm going to do mine, and I've got somebody else, one of the other girls, who can come along with me. And the three of us can go in and do it together." And I was all ready for this. She says: "now go home and tell your husband you're doing your training, and he'll have to pull his hand out and help with the children." So I made up in my mind this was going to be it because, at the time, even though you're an auxiliary, you could go and do your training. So long as you take that written test, you could go and do your training. But you must do the written test. And I went home, full of beans thinking well, I'll have somebody with me that I know and we can go on this course together. And my daughter went poorly at that time. She went poorly at that time, and it

was about over a year that we were... it was off and on with her. And there and then, I couldn't do it because after a year, they stopped doing... auxiliaries were stopped from doing the training. After that you had to go and have so many certificates whereby you can do your...

JH You have to get O-Levels...?

M O-Levels. You had to get five O-Levels to do your training. So I missed it. Because there were a lot of girls - a lot, a lot of nurses - who are good nurses, who did not have five O-Levels. The ones that are coming with five and six O-Levels, they don't want to actually do the nursing work. They want to do the paper-work. But somebody has to do... the patients. But they don't want to do that, you see.

JH Mmm. So what do you feel about that now? I mean, do you think... do you feel frustrated by the fact, right, that you've never been given the kind of... status, if you like, for your experience, and the work you've done and the knowledge? Does that frustrate you, make you angry?

M It does in a way, but I wouldn't feel good if they gave me a status. I wouldn't feel good within myself. Not that I can't do the work, but I haven't gone through the proper training. If I went through the proper training that would be a different thing, but I know after twenty years they recognise you with a badge and things like that. Maybe I will wear it if they tell me exactly why I'm wearing this badge. But until I had gone to a school of nursing, whereby I'd sit down and go through every individual thing, I wouldn't think that they owe me by giving me status now.

JH No.

M No.

JH But the fact that you can't do it now, unless you go and do O-Levels, does that annoy you? Do you think that's unfair, whereas you could have taken the test at one time?

M Yes. I think it's unfair because, like I said, I've got good nurses who didn't have O-Levels. You know, I think they're being unfair there, whereby they're speculating that they want... you must have five O-Levels to become a nurse. JH Is that happening now with Project 2000 and all the changes in nursing? Has it made it more difficult for people who've been [...] nurse for a long time to get into training?

M Well, because of where I am, and night-time, I do not hear about those who want to go and do the training, but I think it will be hard for them. With this 2000, I think it will be hard for them to get in because there's some of the girls who are SENs, and they have to go and do the conversion course. And they say how hard it is to do the conversion, you see, so... it's very, very hard for them. So it will be difficult, yes.

JH Now when you were saying earlier, you were saying that you thought nursing had changed quite a lot over the years since you started. What do you think the main changes are in nursing?

M I think the communication between the patient and the nurse is not what it used to be. There were times, even though you didn't have a lot of staff, you could sit and talk to a patient. Now, the nurses have got so much paper-work to do before they go off duty, that they don't have time to sit down and talk



to the patient. The night staff might have a bit more time but the day staff are running around all the time. And they brought this care plan out, whereby every patient that's admitted have to go through this process. Once upon a time you just put the name, the address, the next of kin, where they work and things like that. Now it's completely different. You have to do all the way through, and you have to sit and talk to them and find out what's been going on in their life and things like that. And that's the only time the nurse have time. But after that she hasn't got time to..., because the amount of paper-work she has to do.

JH And for you do you think it's better now than it used to be?

M For me? For me it's better.

JH Is that cos you've changed on to medical, or do you think attitudes have changed or...?

M Well I think still on the geriatric, I think the attitudes sometimes of the night staff lack something. I don't know what it is. But the morale of the nurses over there is not as what it used to be. Maybe because I am not there any more. If I was there, I wouldn't feel it, but because I've left and gone back...

JH ... See from the outside.

M Yes. Yes. But it's better for me because I can go on the ward at nine o'clock and listen to the report of all the patients, and then I can go round the ward and put what they've said to me to the patient - you know, look at the patient - and I can correspond with that patient. I can sit and talk to him. Just by saying hello to him, "how are you today?", and he can start and tell me things that they might not even know. And then I can report it back to

them.

JH That's true.

M Yeah, so it's good. I get along OK.

JH You get along OK?

M Yeah.

JH And what about the other changes that are happening?

[PHONE RINGS]

JH Do you think nursing is attractive as a career for women now?

M Well my daughter wanted to do nursing, and I steer her away from that. And I'm not sorry I did because it's becoming harder and harder and I don't think eventually... I don't know what's going to happen in nursing but at the moment it is hard, and a lot of the girls get a bit frustrated with it. So I'm glad that my daughter didn't go in that line.

JH Do you think it's hard because of the more physical work or the changes...

M the changes?

JH ... within the NHS?

M The changes in the NHS, yes. Because right now, whether it'll come about or not, they haven't said anything about redundancy yet, but what has come up now, at the last week, they given us part-timers - I work thirty hours a week - and they want us every nineteen weeks - this is what I understand it to be - every nineteen weeks that we work one night without pay. Because we are owing them so many hours, because they giving us an hour for dinner and an hour for tea. And then after nineteen weeks, they taking all those

hours back from us and want us to work a night without pay. There's no way I'm going to do that. There is... I don't know if... I've got a union and if the union is going to step in with them because they're in trust[?] to make us do something like that, that is terrible. Terrible, because... I mean, they want... If you don't do this, you take... You work twenty-eight hours. Rather than thirty, you work twenty-eight hours, and that'd be OK. Which means that you are down in pay then. But if you keep the thirty hours, you work every nineteen weeks - eighteen or nineteen weeks - you work four nights and one night belong to them. That's just not fair in no book at all. I don't know how they come up with that.

JH Were there any other reasons you didn't want your daughter to be a nurse? Like because it's hard work? It's quite physically hard work, and it's stressful work as well to a degree, isn't it? Did that have a bearing on it, do you think?

M I think there's stress, I think... there's stress. But I think she would have made a good nurse but... I'm not sorry. I'm not sorry, no.

JH What is she doing?

M She's a veri... verication clerk. Verification clerk, that's it, at Co-op Chemists. She deals with drugs and things like that, you know.

JH Does she enjoy it?

M Yeah. Oh, yeah. Yeah.

JH Thank you very much indeed for your time.

M Thank you. I'm sorry it couldn't be longer.

[END]

### **APPENDIX III**

#### **SOURCE MATERIALS**

##### **A: Popular Fictions**

##### **B: Recruitment**

##### **C: Autobiographies**

##### **A: Popular fictions**

1) Feature films in alphabetical order by title:

**Carry on Nurse** (GB Gerald Thomas 1959)

**Carry on Again Doctor** (GB Gerald Thomas 1969)

**Carry on Matron** (GB Gerald Thomas 1972)

**Doctor in the House** (GB Ralph Thomas 1954)

**The Feminine Touch** (GB Pat Jackson 1956)

**Green for Danger** (GB Sidney Gilliat 1946)

**The Lady with the Lamp** (GB Herbert Wilcox 1951)

**The Lamp Still Burns** (GB Maurice Elvey 1943)

**The National Health or Nurse Norton's Affair** (GB Jack Gold 1973)

**No Time for Tears** (GB Cyril Frankel 1957)

**Sapphire** (GB Basil Dearden 1959)

**Twice Around the Daffodils** (GB Gerald Thomas 1962)

**Vigil in the Night** (US George Stevens 1940)

**White Corridors** (GB Pat Jackson 1951)

2) Television serial dramas

**Emergency Ward Ten** (ATV 1957-67)

**Dr. Kildare**, American import (ITV 1961-64, 1965-66)

**Marcus Welby M.D.**, American import (ITV 1969)

**Ben Casey**, American import (ITV 1960-66)

**General Hospital** (ITV 1970-72)

**Angels** (BBC 1 1975-76, 1978-84)

**Casualty** (BBC 1 1985-continuing)

3) Books for girls.

Dore Boylston, Helen:

**Sue Barton, Student Nurse** (1939). This edition Knight Books, Leicester, 1971.

**Sue Barton, Visiting Nurse** (1941). This edition Knight Books, Leicester, 1974.

**Sue Barton, Neighbourhood Nurse** (1950). This edition Knight Books, Leicester, 1972.

**Sue Barton, Superintendent Nurse** (1942). This edition Knight Books, Leicester, 1968.

Wells, Helen:

**Cherry Ames, Flight Nurse** (1956). World Distributors Ltd, Manchester.

**Cherry Ames, Chief Nurse** (1957). World Distributors Ltd, Manchester.

**Cherry Ames at Hilton Hospital** (1959). World Distributors Ltd, Manchester.

Tatham, Julie:

**Cherry Ames, Mountaineer Nurse** (1957). World Distributors Ltd, Manchester.

**Cherry Ames, Night Supervisor (1958).** World Distributors Ltd, Manchester.

3) Popular romantic fiction.

Selected doctor/nurse romances published between 1957 and 1976.

**Andrews, L. My Friend the Professor (1960).** Mills and Boon, London.

**Nurse Errant (1961).** Mills and Boon, London.

**Burns, S. Doctor Divine (1966).** Pan Books Ltd, London.

**Cameron, P. Emergency for Dr. Bill (1978).** Mills and Boon, London/Sydney/Toronto. First published as **This Starry Stranger**, 1964.

**Converse, J. Emergency Nurse (1963).** Arrow Books Ltd, London.

**Dell, B. South Sea Island Nurse (1981).** Mills and Boon, London. First published as **Where the Rata Blossoms**, 1968.

**Douglas, S. Southampton Royal (1975).** Mills and Boon, London. Reprinted 1984.

**Ellis, L. Nurse Rona Came to Rothmere (1970).** Harlequin, New York and Toronto. First published by Mills and Boon 1969.

**Linton, C. Too Many Doctors (1975).** Corgi, Transworld Publishers, London.

**Lorraine, A. So Fleeting a Dream (1976).** Mills and Boon, London.

**Nelson, V. Staff Nurse (1957).** Mills and Boon, London.

**Norton, B. Night Duty at Dukes (1960).** Mills and Boon, London. This edition 1974. **St. Julian's Day (1965).** Mills and Boon, London. Reprinted 1970.

**Norway, K. Junior Pro (1959).** Mills and Boon, London. This edition 1974. **The Lambs (1965).** Mills and Boon, London.

**Sears, R. M. Timberline Nurse (1965).** Dell Publishing, New York.

**Stuart, A. Master of Surgery (1958).** Mills and Boon, London.

**Roberts, I. Desert Nurse (1976).** Robert Hale, London. This edition 1978, Mills and Boon, London.

4) Miscellanea

Mills and Boon press release, Mills and Boon 1988

## **B: Nursing Recruitment.**

### **1) Personal communications**

Senior nurses responsible for recruitment in Liverpool:

Mrs B. Hoare (Liverpool Royal Infirmary, 1960s)

Miss H. (Liverpool Royal Infirmary, 1950s)

Mr. H. Rose (Broadgreen Hospital, Liverpool, 1960s)

### **2) Selected recruitment films**

**Hospital Nurse** (GB 1941) Ministry of Information for Ministry of Health documentary.

**Student Nurse** (GB 1945) Overseas recruitment documentary

**Life in Her Hands** (GB 1951) Central Office of Information recruitment feature

### **3) Recruitment literature**

NB. archivists pointed out that some of the earlier documents were in use for long periods of time without revision.

‘Your Chance’ N.R.L. 7 General Nursing (1950) HMSO, London. Reprinted 1958.

Nursing and Midwifery Services (women) careers pamphlet No. 33 (1945 revised 1950, 1958). This edition 1950, Ministry of Labour and National Service, HMSO, London.

‘Nursing at the present day’ (1950s). Nursing Recruitment Service, King Edward’s Hospital Fund, London.

‘How to become a Nurse; a brief guide for men and women’, HSC 102 Careers in the hospital service (1964) Ministry of Health, Ministry of Labour and the Central Office of Information, HMSO, London.

‘SRN’ NL 018 (1964) Ministry of Health, Ministry of Labour and the Central Office of Information, HMSO, London.

‘Your Life in Nursing’ (1965) Nursing Recruitment Service, King Edward’s Hospital Fund, London

‘Nursing Today’ (1965) Nursing Recruitment Service, King Edward’s Hospital Fund, London

'Proud badge of service' NL011/A (1965) Ministry of Health, Ministry of Labour and the Central Office of Information, HMSO, London.

'The Time Between. Preparing for nursing or midwifery training' NI 015 (1965) Ministry of Health, Department of Education and Science and Central Office of Information, HMSO, London.

Come into Nursing NL 032 (1965) Department of Health and Social Security, the Welsh Office and the Central Office of Information, HMSO, London.

You want to be a Nurse? Your Questions Answered. NL.013 (1966) Ministry of Health, Ministry of Labour and the Central Office of Information, HMSO, London

'Nursing' NL.06 (1966) Ministry of Health and the Central Office of Information, HMSO, London

'Nursing. Surely the most rewarding job in the world', NL 08 (1966) Ministry of Health and Central Office of Information, HMSO, London.

'Too old to train for nursing?' (1969) Department of Health and Social Security, HMSO, London.

'A Girl Like You' NL 011 (1970) Department of Health and Social Security, HMSO, London.

'He's stepping out in a career that's different'. NL 020 (1970) Department of Health and Social Security, HMSO, London.

'Men in Professional Nursing, A Career with Status and Prospects' NL 017 (amended 1970), Ministry of Health and Central Office of Information, HMSO, London.

'Want to be a Nurse'? (1970) NL 013, Department of Health and Social Security, HMSO, London.

'Like to be back in nursing?' NL 027 (1972) Department of Health and Social Security and the Central Office of Information, HMSO, London.

'Nursing. A Profession for men' NL 031 (1972) Department of Health and Social Security, HMSO, London

'Someone Special' NL 025 (1972) Department of Health and Social Security, HMSO, London

'You'd make a good nurse' NL 026 (1973) Department of Health and Social Security, HMSO, London



#### 4) Miscellanea

'A Woman's Calling' (1937) National Association of Local Government Officers, London.

'Careers in Nursing' (1969) The Association of Hospital Matrons at the request of The Association of Headmistresses, Association of Hospital Matrons, London.

'Nursing as a Profession' (undated) Agnes Pavey in **The Zodiac**. Royal College of Nursing archives.

**Monthly Film Bulletin** 210, V.18, No 18, pg 48 and 294

#### **C: Popular autobiographical novels**

Andrews, Lucilla (1978) **No Time for Romance**. Corgi Books, Transworld Publishers Ltd, London.

Ash, Joan (1992) **Catch me a Nightingale**. Robert Hale, London.

Dickens, Monica (1942) **One Pair of Feet**. This edition 1957, Penguin Books Ltd, London.

Grant, Jane (1957) **Come Hither Nurse**. Pan Books Ltd, London.

Markham, Stella (1975) **The Lamp was Dimmed: The Story of a Nurse's Training**. Robert Hale, London.

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